5.4 Care Management

The Care Management business area as defined by the MITA 2.0 Framework supports the growing importance of care management as the Medicaid program evolves. Care Management includes:

- Collection of information about the needs of the individual member
- Plan of treatment
- Targeted outcomes
- Information about the individual's health status
- Processes that support individual care management and population management
- Customizable, functional and clinical assessments

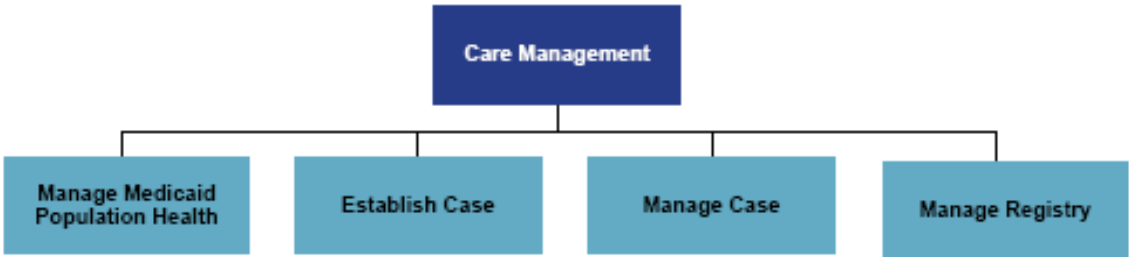
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process

5.4.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Care Management business area, which is shown below. There are four specific Care Management business processes defined by the MITA 2.0 Framework.

Figure 10: MITA Care Management



The RI Medicaid program performs two of these defined business processes:

- Manage Medicaid Population Health
- Manage Case

Table 11: Care Management Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Manage Case	Manage Case	The Office of Medical Review (OMR) of the Department of Human Services (DHS) The LTC Field Offices within the Department of Human Services (DHS) The Division of Development Disabilities (DDD) of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) The Department of Elderly Adults (DEA) The Department of Children, Youth and Families (DCYF)
2	Manage RI Medicaid Population Health	Manage Medicaid Population Health	Department of Human Services (DHS) Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) The Department of Elderly Adults (DEA) The Department of Children, Youth and Families (DCYF) The Department of Health (DOH)

The following MITA Business Processes are not currently performed by RI:

- Establish Case – Covered in Establish Care Plan (Operations Management)
- Manage Registry – No applicable to the current view of RI Medicaid. KidsNet is outside of the Medicaid program. This business process is planned for the 5 year future view.

5.4.2 Care Management Business Process Maturity

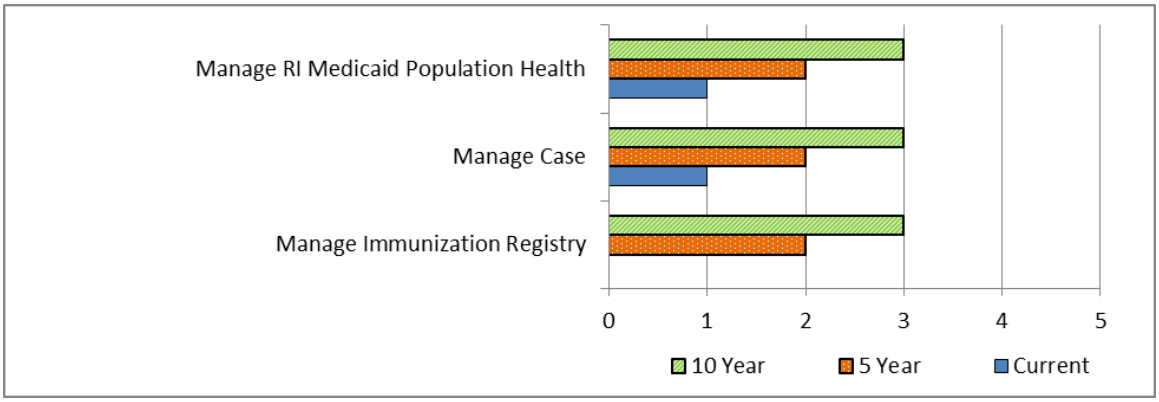
Current View – All Care Management business processes are currently at a capability level 1. Most processes are performed with partial or no automation and do not exchange information efficiently throughout the RI Medicaid program.

5 Year View – All Care Management business processes will progress to a capability level 2 in 5 years, with the introduction of automated rules and coordination of the process across all programs with the implementation of a case management application.

10 Year View – Within 10 years, all Care Management processes will be at a level 3. Standardized queries will assist in managing cases and will trigger automated alerts regarding new services, new providers, changes to cases, and other case management activities. Updates will be distributed to data sharing partners immediately using data sharing standards to improve timeliness and efficiency of the process.

The following chart illustrates each of the Care Management business processes and their current, 5 and 10 year capabilities.

Figure 12: Care Management Business Capability Levels – 10 Year, 5 Year, & Current



5.4.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[6]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include increased enrollment in managed care plans, which may result in a decreased number of beneficiaries whose care may be subject to the prior authorization process. However, greater attention to those with manageable conditions may require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the prior authorization process.[7]

[6] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[7] ibid

- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[8]
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the care planning process.[9]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information to improve care management.[10]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in RIte Share/RIte Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).[11]
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal

[8] ibid
[9] ibid
[10] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[11] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other care management improvements.[12]

Facilitators and Barriers

- A new CMS proposed rule makes it easier for states to provide home and community based services in the Medicaid program. More persons with disabilities who wish to live in the community and not in institutions would be able to do so under the proposed regulations. The proposed rule also clarifies what constitutes a true HCBS setting and sets out new requirements for "person-centered" care plans.
- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business area.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase volume of Medicaid recipients to be managed.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the

[12] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

Department's ability to among other things, ensure Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.[13]

- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[14]
- Increased availability of digital diagnostic information (e.g., lab results and radiology images) will decrease the amount of non-electronic data exchange required to support care management business rules.
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

[13] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7
[14] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

5.5 Contractor Management

Contractor Management business area is defined by the MITA 2.0 Framework as a business area that:

- Accommodates States that have managed care contracts or a variety of outsourced contracts
- Has a common focus (e.g., manage outsourced contracts)
- Owns and uses a specific set of data (e.g., information about the contractor or the contract)
- Uses business processes that have a common purpose (e.g., solicitation, procurement, award, monitoring, management, and closeout of a variety of contract types)

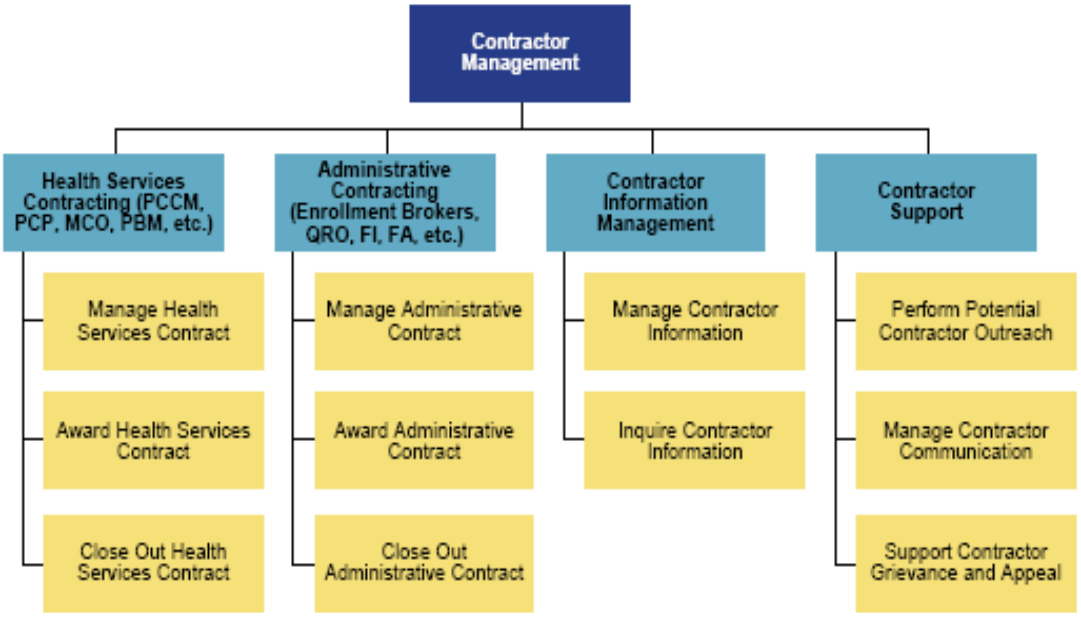
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process

5.5.1 MITA to RI Medicaid Business Process Mapping

There are eleven specific Contractor Management business processes defined by the MITA 2.0 Framework.

Figure 13: MITA Contractor Management



The business processes are overseen primarily by DHS and the Department of Administration (Division of Purchases). The Division of Purchases oversees the entire procurement while DHS is responsible for the execution of the final contract. In addition, The Division of Purchasing streamlines the process to ensure vendors pursuing State contracts have fair and equitable opportunity.

The RI Medicaid program performs ten of the defined business processes:

- Award Administrative Contract / Award Health Services Contract
- Close-out Administrative Contract / Close out Health Services Contract
- Inquire Contractor Information
- Manage Administrative Contract / Manage Health Services Contracting
- Manage Contractor Information
- Perform Potential Contractor Outreach

- Support Contractor Grievance and Appeal

Table 8: Contractor Management Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Award Administrative/Health Services Contract	Award Health Services Contract Award Administrative Contract	Department of Administration, Division of Purchases
2	Close-Out Administrative/Health Services Contract	Close-Out Health Services Contract Close-Out Administrative Contract	Department of Administration, Division of Purchases
3	Manage Administrative/Health Services Contract	Manage Health Services Contract Manage Administrative Contract	Department of Administration, Division of Purchases
4	Inquire Contractor Information	Inquire Contractor Information	Department of Administration, Division of Purchases
5	Manage Contractor Information	Manage Contractor Information	Department of Administration, Division of Purchases
6	Perform Potential Contractor Outreach	Perform Potential Contractor Outreach	Department of Administration, Division of Purchases
7	Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal	Division of Legal Services

The following MITA Business Processes is not currently performed by RI:

- Manage Contractor Communication – no formal process currently exists. This business process is planned for the 5 year future view.

5.5.2 Contractor Management Business Process Maturity

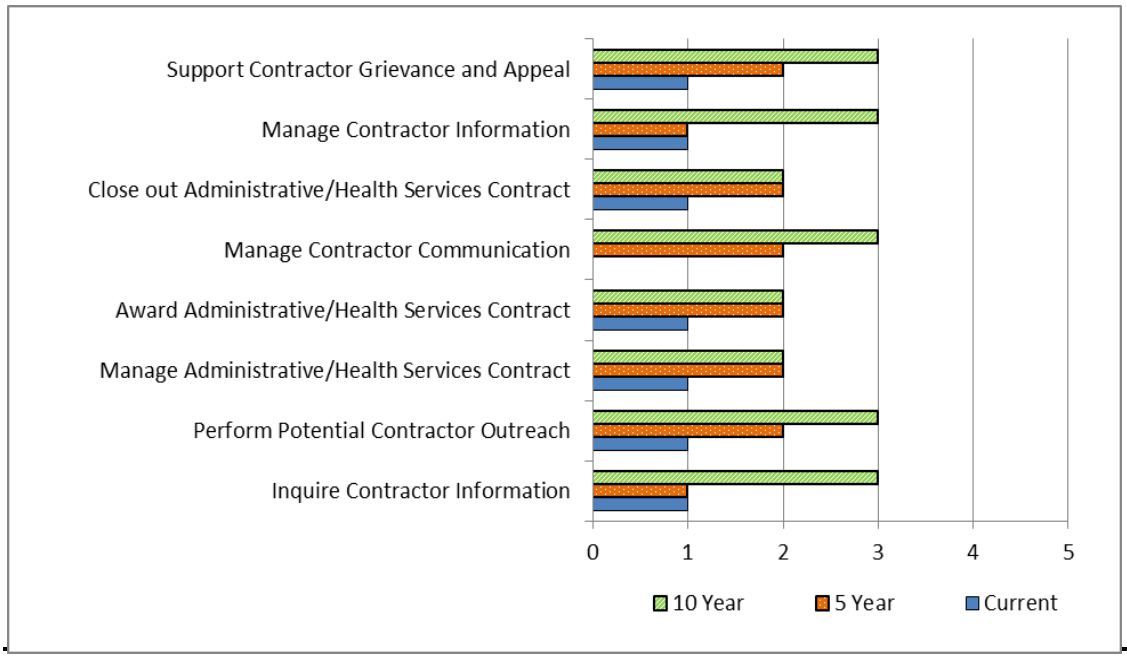
Current View – The business processes for Contractor Management currently rate at a Level 1 business capability. This is due to highly manual processing and lack of supporting technology.

5 Year View – Within 5 years the Contract Management business processes will progress to a level 2 capability. Application data is standardized within the state. Contractors can submit applications via a portal. The new Provider Enrollment Portal will facilitate a majority of the 5 year goals related to communication, outreach and management of contractor information.

10 Year View – Over the next 10 years there will be some changes to Contractor Management that will allow some business processes to reach a Level 3. Turnaround time can be immediate with automated verifications. Application data is further standardized within the state.

The following chart illustrates each of the Contractor Management business processes and their current, 5 and 10 year capabilities.

Figure 14: Contractor Management Business Capability Levels – 10 Year, 5 Year, & Current



5.5.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- The former EOHHS Modernization Initiative included simplification of state forms/applications, enhanced citizen access to services, technical infrastructure modernization to upgrade/replace outmoded legacy hardware and software, improved case management including data integration and improved reporting capabilities. Although this initiative has been disbanded under the new EOHHS administration, the goal of simplification is still in progress under other initiatives such as the Health Insurance Exchange initiative. This will lead to increased user-driven functionality such as Benefits Screeners, On-Line Eligibility, and On-Line Application intake for multiple state programs.[15]
- A goal of the Global Waiver is to advance efficiencies through interdepartmental cooperation. Contractor communications can be centralized to support this coordination.[16]

Facilitators and Barriers

- RI-FANS Electronic Submission of Bids project will include a repository of bid opportunities, electronic submission of bids, purchase orders and invoices, electronic submission of question and email notifications.
- Online provider portal for enrollment, status changes and communication to the provider community.
- Expanded and increased use of the CHOICES Data Warehouse will facilitate direct access to data needed to research grievance and appeal cases.

[15] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 55
[16] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

- The upcoming new FA contract and replacement of the current MMIS will limit available resources. With the focus on larger projects such as the reprocurement of the MMIS, resources will not be available for process improvements initiatives related Contractor Management in the upcoming 5 years.

5.6 Member Management

The Member Management business area as defined in the MITA 2.0 Framework is a collection of business processes focus on:

- Communications between the Medicaid agency and the prospective or enrolled beneficiary
- Actions that the agency takes on behalf of the beneficiary
- Management of the shared common set of beneficiary-related data

The goal for this business area is to improve health care outcomes and raise the level of consumer satisfaction.

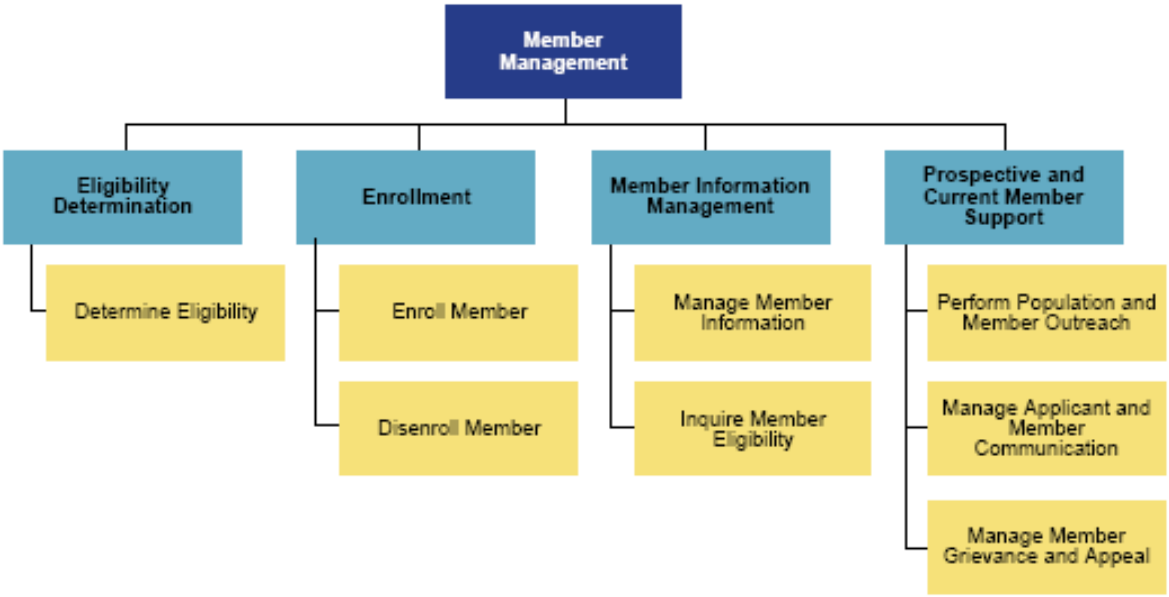
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process.

MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Member Management business area, which is shown below. There are eight specific Member Management business processes defined by the MITA 2.0 Framework. The RI Medicaid program performs each of these processes, some of them of which are performed in duplicate due to variation in processing (manual vs. automated), system use, and standardization.

Figure 15: MITA Member Management



The RI Medicaid program performs all of the defined business processes, with Determine Eligibility performed differently for several programs. These separate business processed identified in the Current View will be eliminated with the merging of this business process across similar functions. The overall Determine RI Medicaid Eligibility process will represent the standard approach, the business rules for which may be customized for each program's needs.

- Determine Eligibility
- Disenroll Member
- Enroll Member

- Inquire Member Eligibility
- Manage Applicant and Member Communication
- Manage Member Grievance and Appeal
- Manage Member Information
- Manage Member Information
- Perform Population and Member Outreach

Table 9: Member Management Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Determine RI Medicaid Eligibility	Determine Eligibility	Department of Human Services , Medicaid Case Workers
2	Determine BCCTP Eligibility	Determine Eligibility	Department of Human Services
3	Determine Respite Care for Children Eligibility	Determine Eligibility	Department of Human Services
4	Enroll Managed Care Member	Enroll Member	Department of Human Services
5	Disenroll RI Medicaid Member	Disenroll Member	Department of Human Services
6	Inquire RI Medicaid Member Eligibility	Inquire Member Eligibility	Department of Human Services
7	Manage RI Medicaid Member Information	Manage Member Information	Department of Human Services
8	Manage BCCTP Member Information	Manage Member Information	Department of Human Services
9	Manage RI Medicaid Applicant and Member Communication	Manage Applicant and Member Communication	Department of Human Services
10	Manage RI Medicaid Member Grievance and Appeal	Manage Member Grievance and Appeal	Legal Division, Hearing Office

#	RI Medicaid Business Process	MITA Business Process	Owner
11	Perform RI Medicaid Population and Member Outreach	Perform Population and Member Outreach	Department of Human Services

5.6.1 Member Management Business Process Maturity

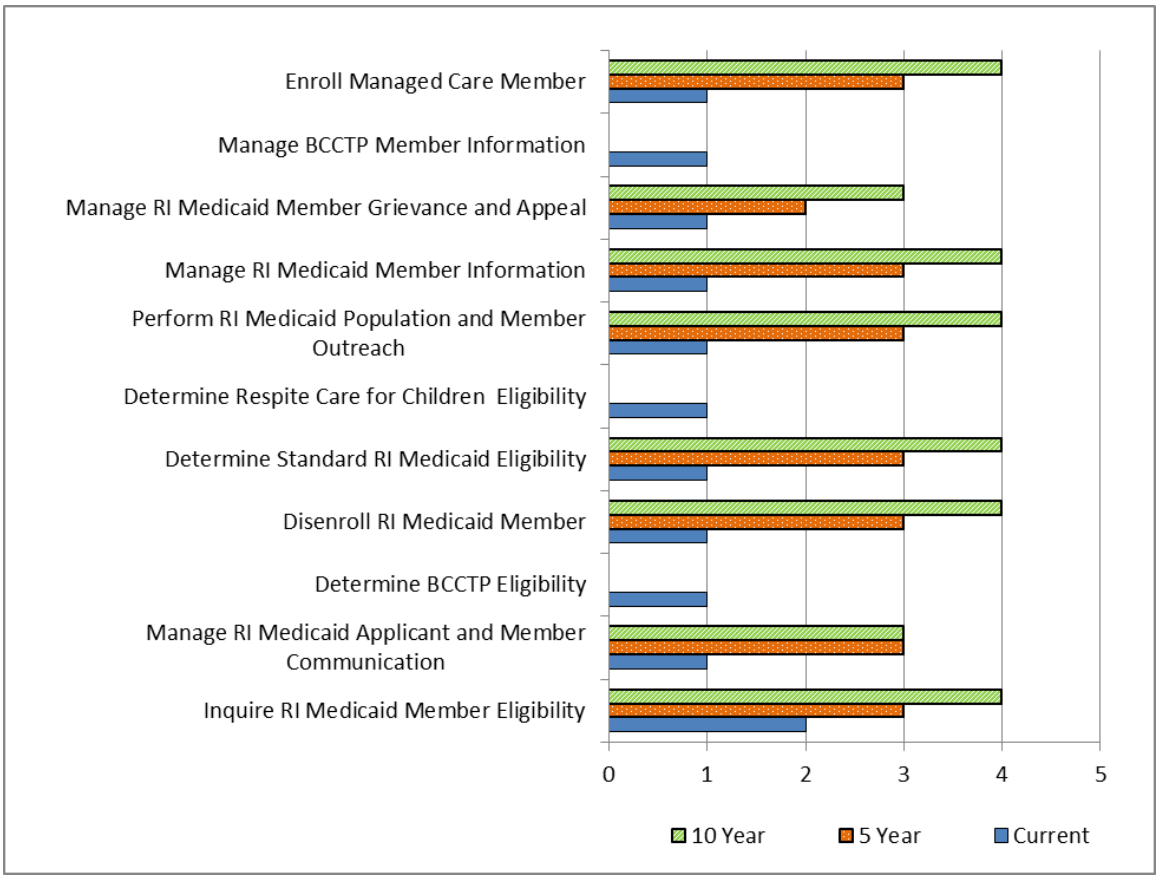
Current View – Most business processes for Member Management currently rate at a Level 1 business capability. Due to variations in types of enrollment, different processing methods (paper vs. electronic), different supporting technology, non-standardization, and lack of data integration, the majority of these processes currently rate at the lowest level of overall capability.

5 Year View – Within 5 years Member Management processes will become more automated and standardized and reach a level 3. A single, automated pathway for beneficiaries to apply to the RI Medicaid program and enroll in the various programs will improve timeliness and increase efficiency for this business process. Automated rules and enrollment coordination will allow beneficiaries to immediately enroll into programs in which they are eligible and will receive services appropriate to their needs. Applications will only be submitted electronically with verification and responses in real time. Enrollment data for all beneficiaries will be stored in a Member Registry that can be accessed securely by members, providers, state staff, and contractors.

10 Year View – Over the next 10 years there will be significant changes to Member Management that will allow all business processes to reach a Level 4. The process will provide members with the most appropriate benefit packages based on clinical needs and member preferences. Services and providers will be selected within funding limits of benefit packages available to the member based on clinical and socio-economic factors, as well as member preferences. Validation process steps will be automated and will update the member record immediately, as well as notify parties of any changes to member status.

The following chart illustrates each of the Member Management business processes and their current, 5 and 10 year capabilities.

Figure 16: Member Management Business Capability Levels – 10 Year, 5 Year, & Current



5.6.2 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- The former EOHHS Modernization Initiative included simplification of state forms/applications, enhanced citizen access to services, technical infrastructure modernization to upgrade/replace outmoded legacy hardware and software, improved case management including data integration and improved reporting capabilities. Although this initiative

has been disbanded under the new EOHHS administration, the goal of simplification is still in progress under other initiatives such as the Health Insurance Exchange initiative. This will lead to increased user-driven functionality such as Benefits Screeners, On-Line Eligibility, and On-Line Application intake for multiple state programs.[17]

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate improved access to health information required for the determination of eligibility.[18]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include increased enrollment in managed care plans.[19]

Facilitators and Barriers

- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.
- States needing to overhaul their computer systems to handle the changes in Medicaid enrollment under the Affordable Care Act will have 90 percent of the cost paid by the federal government, according to a new rule published April 14th, 2011 by CMS. Under this new rule, states may receive a 90 percent federal matching rate to assist states in the design,

[17] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 55
[18] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[19] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

development, installation or enhancement of eligibility determination systems through December 31, 2015.[20]

- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.[21]
- The RI DHS online benefit screener is being updated to add additional programs as well as increased functionality. An individual will be able see what programs they may qualify for among the many LTC options available after answering a series of questions. The functionality of this online portal could be updated to include all Medical Assistance programs or all state social services.
- The Affordable Care Act requires the establishment of an internet Website (portal) through which individuals and small businesses can obtain information about the insurance coverage options that may be available to them in their State. These options include Medicaid. The RI DHS initiative to address this new requirement is the Health Insurance Exchange (HIX) project. The recommendations made out of this project will influence the

[20] http://www.regulations.gov/#!documentDetail;D=CMS-2010-0251-0044
[21] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

next steps in the department replacing the state's eligibility system, InRhodes.[22]

- The Medicaid EHR incentive program will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation. Access to member's EHR will advance the capability of member management functions with the access to clinical data to make decisions.[23]

[22] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1103(a)
[23] http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

5.7 Operations Management: Authorize Services

Authorize Service business processes fall under MITA's Operations Management. These functions are grouped separately, as they are managed distinctly from the claims processing and other Operations Management functions.

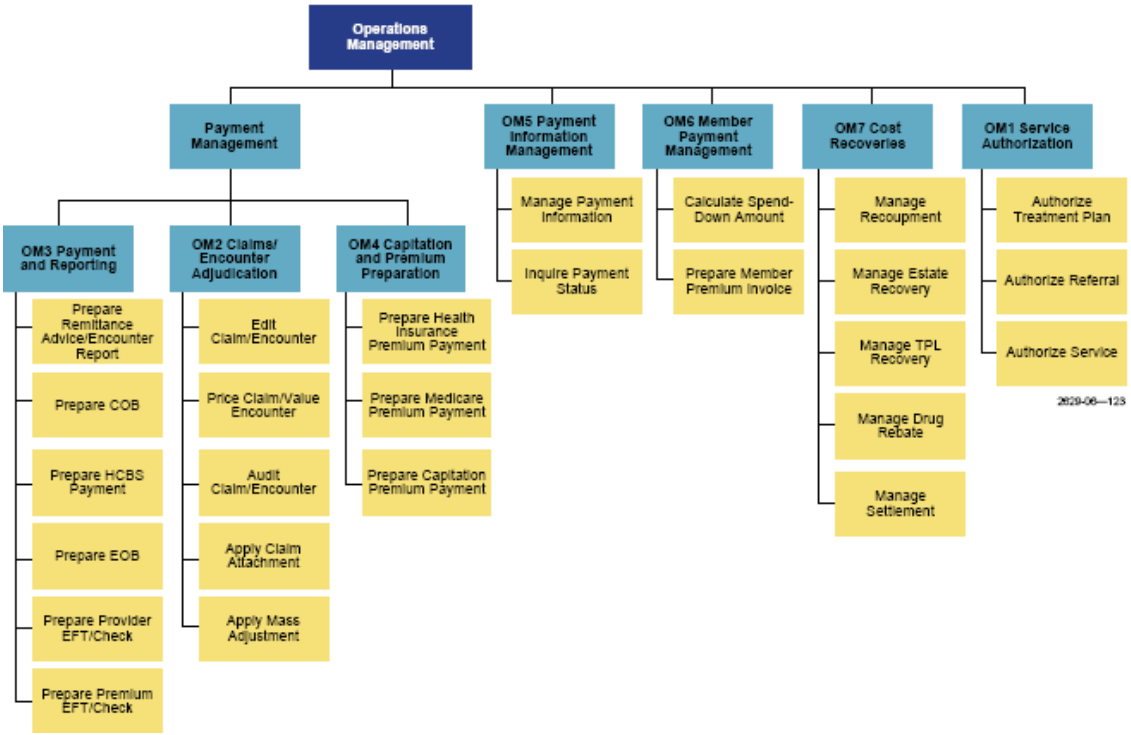
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process.

5.7.1 ITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Operations Management business area, which is shown below.

Figure 17: MITA Operations Management



There are three MITA business processes related to service authorizations:

- Authorize Service
- Authorize Referral
- Authorize Treatment Plan

The RI Medicaid program performs two of the defined business processes:

- Authorize Service
- Authorize Treatment Plan

Table 10: Authorize Services Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Authorize Personal Choice Waiver Service	Authorize Service	Office of Institutional and Community Services and Support
2	Authorize RI Medicaid Service	Authorize Service	Operations and Payments
3	Establish Care Plan	Authorize Treatment Plan	Office of Institutional and Community Services and Support

The following MITA Business Process is not currently performed by RI:

- Authorize Referral – Not applicable to RI Medicaid

5.7.2 Authorize Services Business Process Maturity

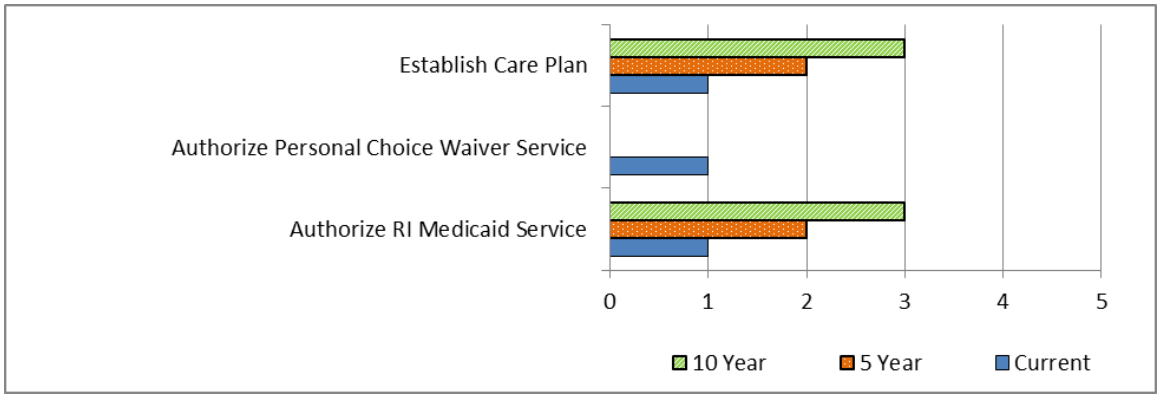
Current View – Most Authorize Service business processes are currently at a capability level 1. While some portions of the processes are automated, most of the activities are paper-based, lack use of national standards, and do not exchange information efficiently within the RI Medicaid program or with its external business partners.

5 Year View – All Authorize Service business processes will progress to a capability level 2 in 5 years, with increased automation and standardization improving accuracy and timeliness. Within 5 years, all aspects of the Authorize Personal Choice Waiver Services process will be incorporated into the Mange Case business process in the Care Management business area. The authorizing of non-medical supplies or service from a client's Personal Choice Waiver budget will become managed within an integrated case management system, which will allow for non-medical requests to be properly reviewed and approved or denied more efficiently and effectively.

10 Year View – Integrated and automated authorization processes will use real-time, standardized data and business rules, which will support a level 3 capability for this business process within 10 years.

The following chart illustrates each of the Authorize Services business processes and their current, 5 and 10 year capabilities.

Figure 18: Authorize Services Business Capability Levels – 10 Year, 5 Year, & Current



5.7.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[24]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include increased enrollment in managed care plans, which may result in a decreased number of beneficiaries whose care may be subject to the prior authorization process. However, greater attention

[24] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

to those with manageable conditions may require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the prior authorization process.[25]

- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[26]
- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and community-based Services. This will require improved coordination with care managers (e.g., community-based or from within the Medicaid program), which may result in further enhancements to the care planning process.[27]
- As part of Community Living Initiative, HHS is working with several Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), to implement solutions that address barriers to community living for individuals with disabilities and older Americans.
- A goal of the Global Waiver is to ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice.[28]
- A goal of the Global Waiver is to advance efficiencies through interdepartmental cooperation.[29]

[25] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[26] ibid
[27] ibid
[28] ibid

Facilitators and Barriers

- A new CMS proposed rule makes it easier for states to provide home and community based services in the Medicaid program. More persons with disabilities who wish to live in the community and not in institutions would be able to do so under the proposed regulations. The proposed rule also clarifies what constitutes a true HCBS setting and sets out new requirements for "person-centered" care plans.
- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process. An MMIS system with enhancements will improve the ability to integrate MMIS-associated data with other state applications and databases.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase prior authorization volume.
- HIPAA-compliance with implementing and utilizing the ASC X12N Health Care Services Review – Request for Review and Response (278) are consistent with improvement in the MITA capability levels.
- Increased availability of digital diagnostic information (e.g., lab results and radiology images) will decrease the amount of non-electronic data exchange required to support prior authorization business rules.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new,

[29] ibid

agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.[30]

- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.

[30] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

5.8 Operations Management: Third Party Liability

The RI Medicaid program performs MITA Operations Management business processes under the purview of Third Party Liability. These processes are distinct enough to be categorized as their own RI Medicaid business area.

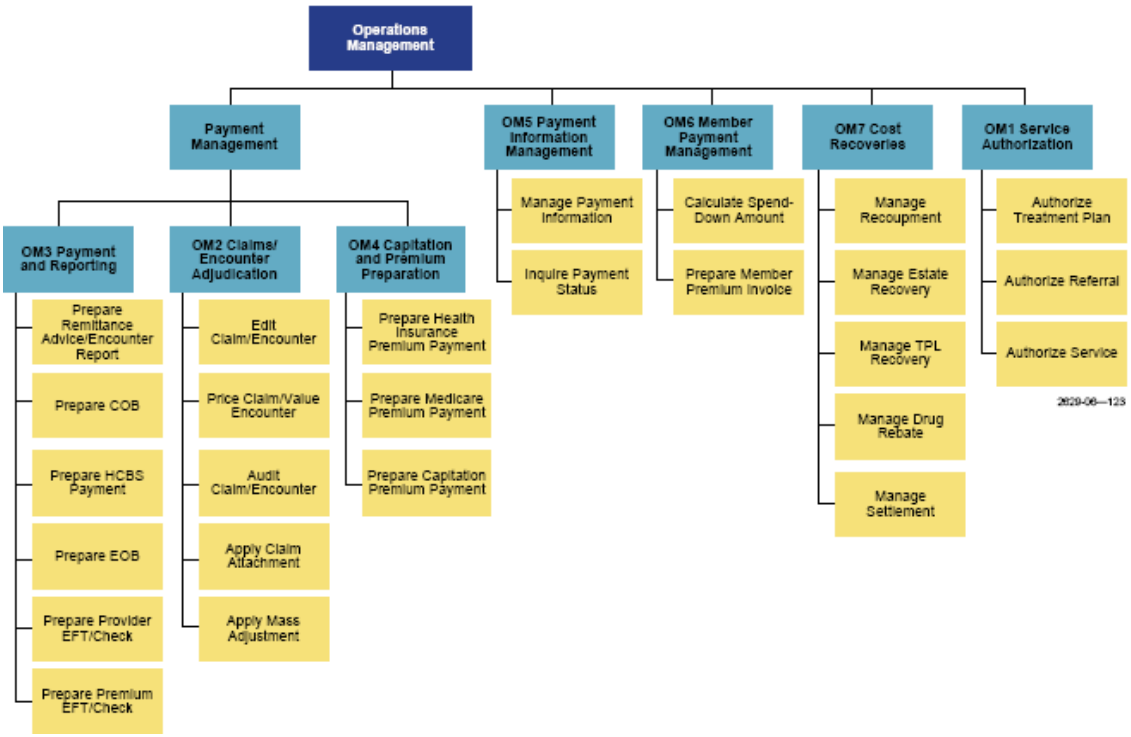
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinders the maturity of the business process.

5.8.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Operations Management business area, which is shown below.

Figure 19: MITA Operations Management



There are five MITA business processes performed for TPL processing, including recovery and payment.

- Manage Drug Rebate
- Manage Estate Recovery
- Manage Recoupment
- Manage Settlement
- Manage TPL Recovery

Table 11: Third Party Liability Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Manage RI Medicaid Drug Rebate	Manage Drug Rebate	Third Party Liability Unit
2	Manage RI Medicaid Estate Recovery	Manage Estate Recovery	Third Party Liability Unit
3	Manage RI Medicaid Recoupment	Manage Recoupment	Third Party Liability Unit
4	Manage Hospital Cost Settlements	Manage Settlement	Rate Setting Unit
5	Manage RI Medicaid TPL Recovery	Manage TPL Recovery	Third Party Liability Unit

5.8.2 Third Party Liability Business Process Maturity

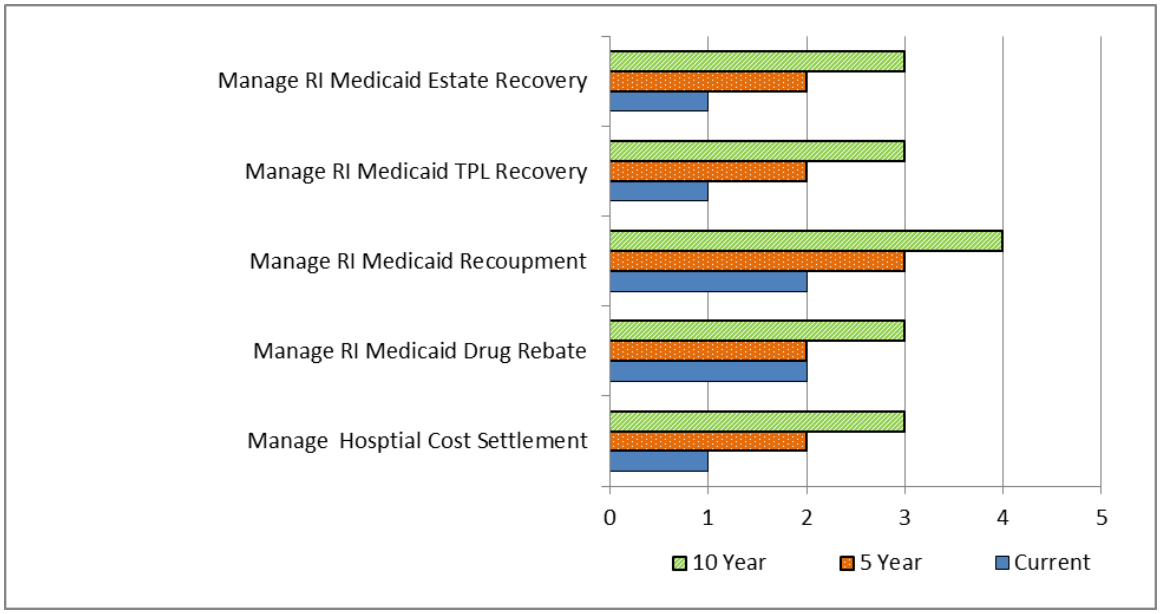
Current View – All business processes for TPL currently rate at a Level 1 or level 2 business capability. Due to a large amount of non-standardization and lack of integration, however, many of these processes currently rate at the lowest level of capability.

5 Year View – Within 5 years TPL processes will become more automated and standardized. Processes will be almost completely automated with improved data exchange between business partners. These improvements will move most TPL business processes to a Level 2 capability. RI Medicaid may leverage some of the existing processes and supporting technology that rate at a higher level, such as Prepare Medicaid Remittance Advice and Prepare RIte Share Premium Payment, to improve TPL related business processes.

10 Year View – Over the next 10 years there will be significant changes to TPL that will allow most business processes to reach a Level 3. Changes will include immediate processing via federated architectures and use of real-time clinical data.

The following chart illustrates each of the Third Party Liability business processes and their current, 5 and 10 year capabilities.

Figure 20: Third Party Liability Business Capability Levels – 10 Year, 5 Year, & Current



5.8.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this may include improved analysis of Medicaid service utilization data that could influence decisions related the Medicaid formulary based on their historical or expected effectiveness.[31]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information.[32]

[31] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[32] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft

- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[33]
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to file a lien against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid.[34]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[35]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business area.

[33] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[34] ibid
[35] ibid

- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase retail pharmacy volume.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[36]
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.[37]
- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management and related functions.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the volume of estate recoveries for those in long-term care setting.

[36] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[37] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 6

5.9 Operations Management: Claims Processing

The Operations Management business area as defined by the MITA 2.0 Framework is the focal point of most State Medicaid organizations. It includes:

- Operations that support the payment of providers, managed care organizations, other agencies, insurers, and Medicare premiums;
- Receipt of payments from other insurers, providers, and member premiums; and
- All information associated with service payment and receivables.

The RI Medicaid Claims Processing Business Area represents a piece of the overall Operations Management business processes.

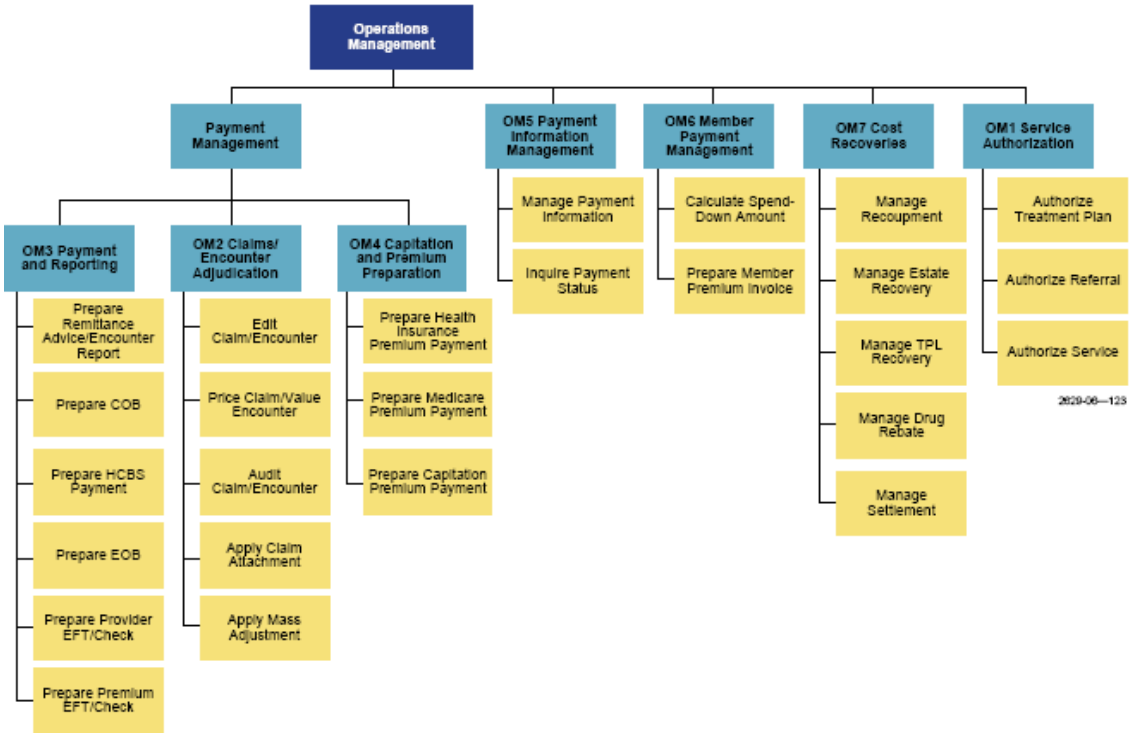
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinders the maturity of the business process.

5.9.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Operations Management business area, which is shown below.

Figure 21: MITA Operations Management



There are thirteen claims specific Operations Management business processes defined by the MITA 2.0 Framework, ten of which are performed for RI Medicaid Claims processing.

- Apply Claim Attachment
- Apply Mass Adjustment
- Calculate Spend-Down Amount
- Audit Claim/Encounter
- Edit Claim/Encounter
- Audit Claim/Encounter
- Edit Claim/Encounter

- Inquire Payment Status
- Price Claim/Value Encounter
- Prepare EOB
- Prepare Provider EFT/Check
- Prepare Premium EFT/Check
- Prepare Remittance Advice/Encounter Report

Table 12: RI Medicaid Claims Processing Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Apply RI Medicaid Claim Attachment	Apply Claim Attachment	Medicaid Claims Unit
2	Apply Void and Replace	Apply Mass Adjustment	Medicaid Claims Unit
3	Calculate Medically Needy Spend-Down Amount	Calculate Spend-Down Amount	RI Medicaid Field Offices
4	Edit and Audit RI Medicaid Encounter	Audit Claim/Encounter Edit Claim/Encounter	Medicaid Claims Unit
5	Edit and Audit RI Medicaid Claim	Audit Claim/Encounter Edit Claim/Encounter	Medicaid Claims Unit
6	Inquire RI Medicaid Payment Status	Inquire Payment Status	Medicaid Claims Unit
7	Price RI Medicaid Claim	Price Claim/Value Encounter	Medicaid Claims Unit
8	Prepare Recipient Explanation of Member Benefits	Prepare EOB	Medicaid Claims Unit
9	Prepare RI Medicaid Provider/Premium EFT	Prepare Provider EFT/Check Prepare Premium EFT/Check	Medicaid Financial Unit
10	Prepare RI Medicaid Remittance Advice	Prepare Remittance Advice/Encounter Report	Medicaid Claims Unit

The following MITA Business Processes are not performed by RI:

- Manage Payment Information - Not applicable to RI Medicaid
- Prepare COB - Not applicable to RI Medicaid
- Prepare HCBS Payment – Covered in Prepare RI Medicaid Provider and Premium EFT

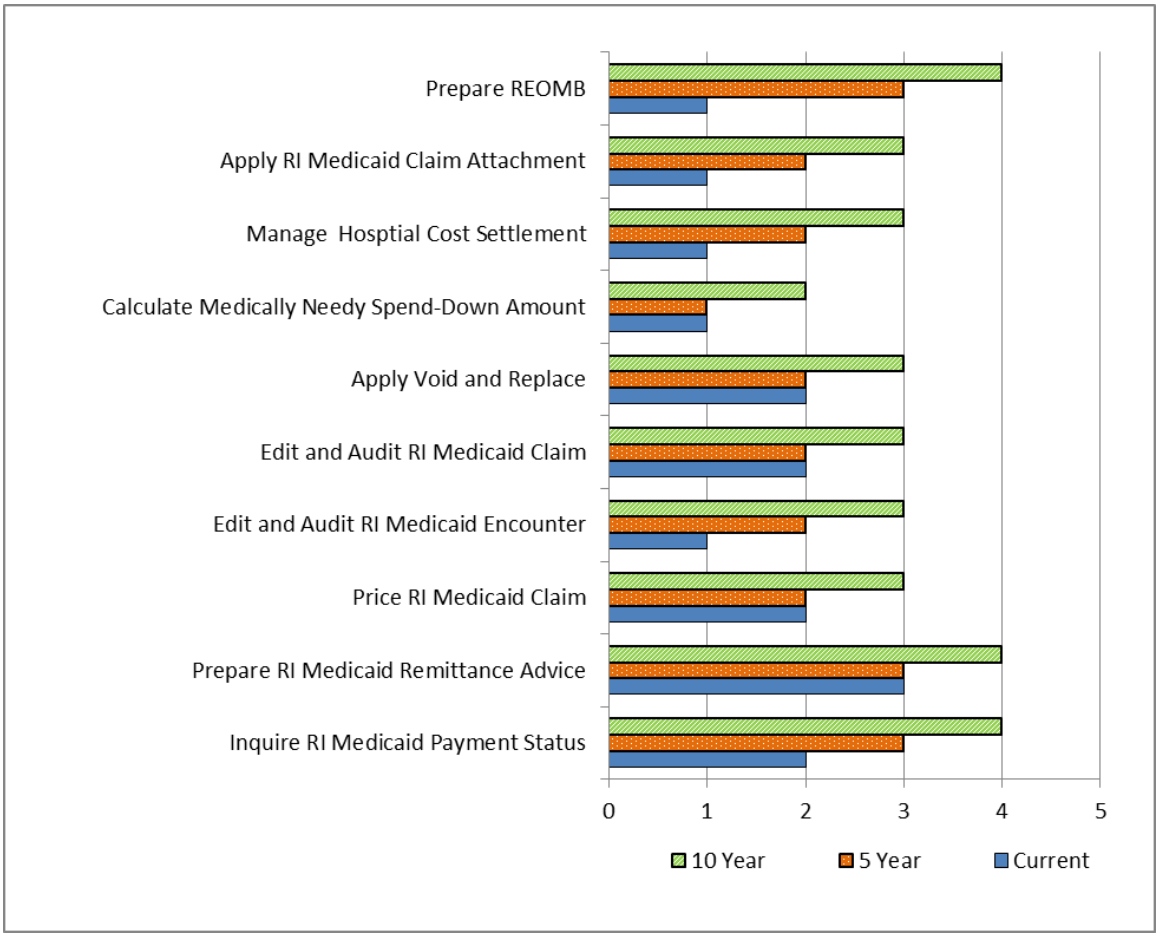
5.9.2 Claims Processing Business Process Maturity

Current View – Most business processes for RI Medicaid Claims currently rate at a Level 2 business capability. Higher levels of maturity are found with electronic submission of claims and immediate turnaround for some business processes that utilize a web portal. Some manual intervention is still required and not all transactions are currently HIPAA compliant.

5 Year View – Within 5 years RI Medicaid processes will become increasingly automated and standardized. Information and services are more accessible among the agency and recipients; processes are streamlined; thereby results are improved. Currently mature business processes will be leveraged to improve lower mature areas. A level 3 maturity will be seen in most business processes.

10 Year View – Over the next 10 years there will be changes to RI Medicaid Claims Processing that will allow business processes to reach a Level 4 in some areas. Direct access by the authorizing agency to clinical information; automation of requests; decisions by payer automatically rendered as the recipient's electronic health record is updated by provider; accuracy improved because decisions are based on clinical evidence; manual intervention limited to exceptions.

Figure 22: Claims Processing Business Capability Levels – 10 Year, 5 Year, & Current



5.9.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health

Information Exchange (HIE). HIT/HIE will facilitate access to health information.[38]

- The Affordable Care Act calls for the establishment of an Interim Final Rule for Standards and Operating Rules for health Claims Attachments not later than January 1, 2014. Compliance with this federal mandate will facilitate maturity in this business process.[39]
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization and payments.[40]
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively members financially responsible prior to Medicaid payment for any medical services.[41]
- Ensuring that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[42]
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create

[38] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[39] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1104(c)(3)
[40] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[41] ibid
[42] ibid

mechanisms that support the Department's goal of rewarding improved plan performance.[43]

- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[44]
- HIPAA initiative to migrate health care industry from version 004010A1 to version 005010A1/A2 and from NCPDP 5.1 to D.0 and the new subrogation transaction NCPDP 3.0.
- A goal of the Global Waiver is to promote accountability and transparency.[45]
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option

[43] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[44] ibid
[45] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.[46]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.
- Increased availability of digital diagnostic information (e.g., lab results and radiology images) will decrease the amount of non-electronic data exchange required to claims processing business rules.
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase the need to determine a member's financial responsibility more effectively and efficiently.
- The method by which the Fiscal Agent receives encounter data is currently non-standard. There is data accuracy, integrity and timeliness issues with the current encounter data that impede the ability for the Department to utilize the encounter data for program management activities.
- A variety of incentives exist for health plans to submit timely and accurate encounter data. An encounter data component in the health plan

[46] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

capitation calculation provides health plans with an incentive to submit accurate, timely, and a consistent volume of data.

- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[47]
- EOHHS accountability and transparency goal to disclose information about reimbursement rates and payments on a regular basis.[48]

[47] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[48] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 6

5.10 Operations Management: Premium Payments

Within the Operations Management business area for the RI Medicaid program, several business processes are related to payment of premiums. These processes are distinct enough to be categorized as their own RI Medicaid business area.

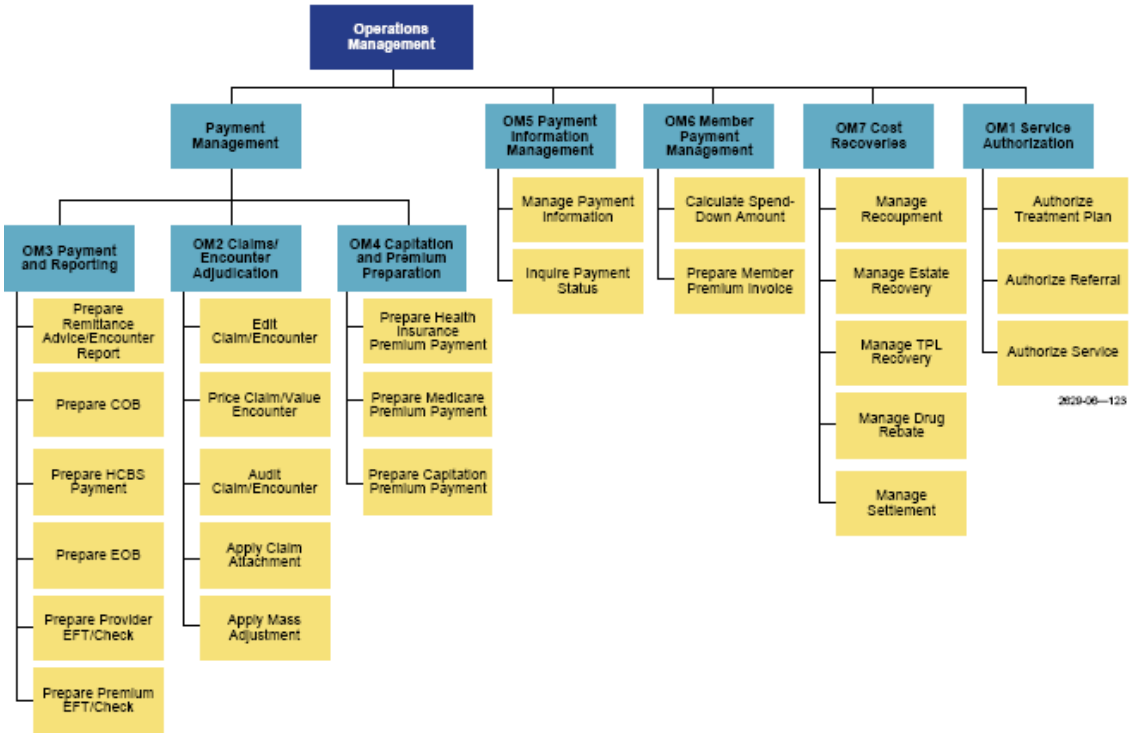
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process.

5.10.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the Operations Management business area, which is shown below.

Figure 23: MITA Operations Management



There are four MITA business processes performed for Premium Payment processing:

- Prepare Health Insurance Premium Payment
- Prepare Member Premium Invoice
- Prepare Medicare Premium Payment
- Prepare Capitation Premium Payment

Table 13: Premium Payment Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Prepare RIte Share Premium Payment	Prepare Health Insurance Premium Payment	Medicaid Claims Unit
2	Prepare RIte Care Member Premium Invoice	Prepare Member Premium Invoice	Medicaid Claims Unit

#	RI Medicaid Business Process	MITA Business Process	Owner
3	Prepare Medicare Premium Payment	Prepare Medicare Premium Payment	EOHHS Budgets and Accounting
4	Prepare Capitation Premium Payment	Prepare Capitation Premium Payment	Medicaid Claims Unit

5.10.2 Premium Payment Business Process Maturity

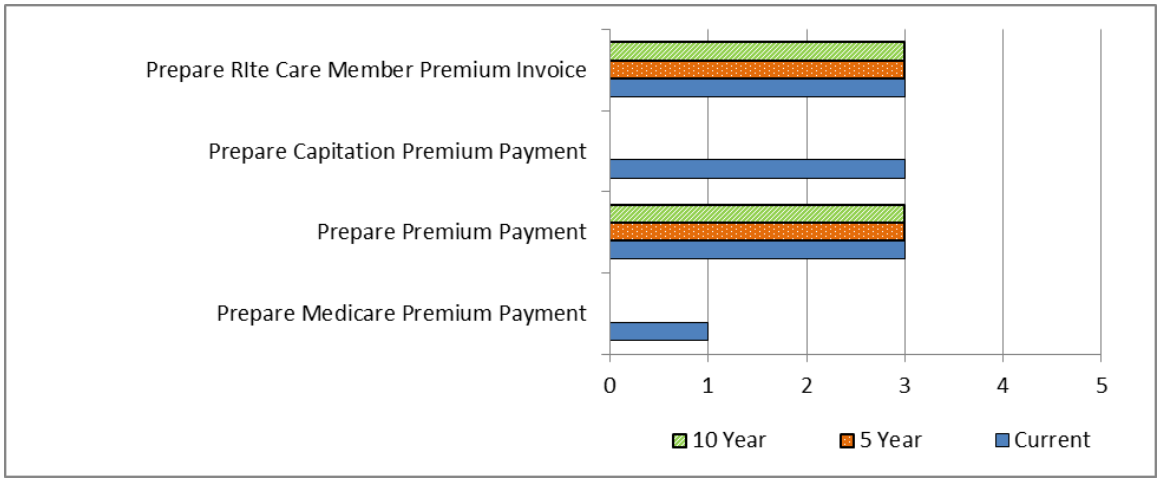
Current View – The Capitation Premium Payment and RIte Share Premium Payment processes are currently functioning at a level 3 capability with the use of the automated HIPAA standard X12 820 Premium Payment transaction. The Medicare Premium Payment process is a manual process and it not incorporated into the MMIS, resulting in a level 1 maturity.

5 Year View – Within the next 5 years, the Capitation, Medicare and RIte Share premium payment processes will follow the standard Prepare Premium Payment business process. All aspects of the Prepare Premium Payment will remain at a capability level 3 in 5 years. There currently are no major initiatives underway that are expected to significantly impact the capabilities for this business process in the next 5 years. The RIte Care Member Premium Invoice process will be incorporated into the Prepare Remittance Advice in the Operations Management: Claim Processing business area.

10 Year View – Within 10 years, all aspects of these processes will remain at a level 3.

The following chart illustrates each of the Premium Payment business processes and their current, 5 and 10 year capabilities.

Figure 24: Premium Payment Business Capability Levels – 10 Year, 5 Year, & Current



5.10.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- Increased accountability and fiscal integrity are among the main goals of the Global Waiver. This business process contributes to the program's ability to cost-avoid by utilizing other health coverage available to the beneficiary.[49]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in RIte Share/RIte Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).[50]
- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health

[49] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[50] ibid

Information Exchange (HIE). HIT/HIE will facilitate access to health information required for determination of eligibility.

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business area.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[51]

[51] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5

5.11 Program Integrity Management

The Program Integrity business area as defined by the MITA 2.0 Framework incorporates those business activities that focus on program compliance. Program Integrity collects information about an individual provider or member to assist with cost-avoidance and anti-fraud activities.

The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinders the maturity of the business process.

5.11.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the MITA Program Integrity business area, which is shown below.

Figure 25: MITA Program Integrity

There are two Program Integrity business processes defined by the MITA 2.0 Framework, both of which are performed by RI Medicaid.

- Identify Candidate Case
- Manage Case

Table 14: RI Medicaid Program Integrity Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Identify RI Medicaid Candidate Case	Identify Candidate Case	DHS Program Integrity Section
2	Manage RI Medicaid Case	Manage Case	DHS Program Integrity Section

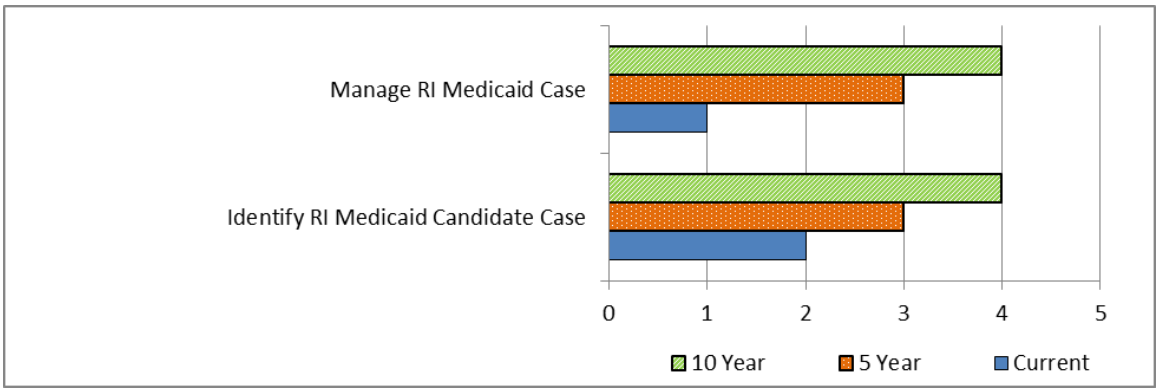
5.11.2 Program Integrity Business Process Maturity

Current View – The Program Integrity business processes for RI Medicaid are currently split between level 1 and level 2 business capabilities. While much of the investigative process involves manual effort, data access and accuracy are enhanced with the centralized web-based case tracking tool.

5 Year View – All Program Integrity business processes will progress to a capability level 3 in 5 years, with improved automation and standardization in the way fraud is detected and cases are opened and managed.

10 Year View – Within 10 years, all Program Integrity business processes will improve to a level 4 capability, with real-time clinical data leveraged through the Department's increasingly federated systems architecture and leads provided immediately to investigators.

Figure 26: Program Integrity Business Capability Levels – 10 Year, 5 Year, & Current



5.11.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This business process contributes to the program's ability to identify prospectively potentially inappropriate service utilization.[52]
- The 2010 State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information. Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create

[52] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2

mechanisms that support the Department's goal of rewarding improved plan performance.[53]

- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser. More enrollees in Managed Care will increase the volume of encounters and facilitate the need for cleaner, more accurate data.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[54]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business area.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the Medicaid program, which could increase volume of Medicaid recipients to be managed.

[53] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[54] ibid

- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity.[55]
- Under the Global Waiver, the goal to stimulate innovation and adoption of best practices.[56]
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business area.

[55] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[56] ibid

5.12 Program Management

The Program Management business area as defined in the MITA 2.0 Framework houses the strategic planning, policy making, monitoring, and oversight activities of the agency. These activities depend heavily on access to timely and accurate data and the use of analytical tools.

Program Management is at the heart of the Medicaid enterprise and the control center for all operations including:

- Benefit plan design
- Rate setting
- Healthcare outcome targets
- Cost management decisions

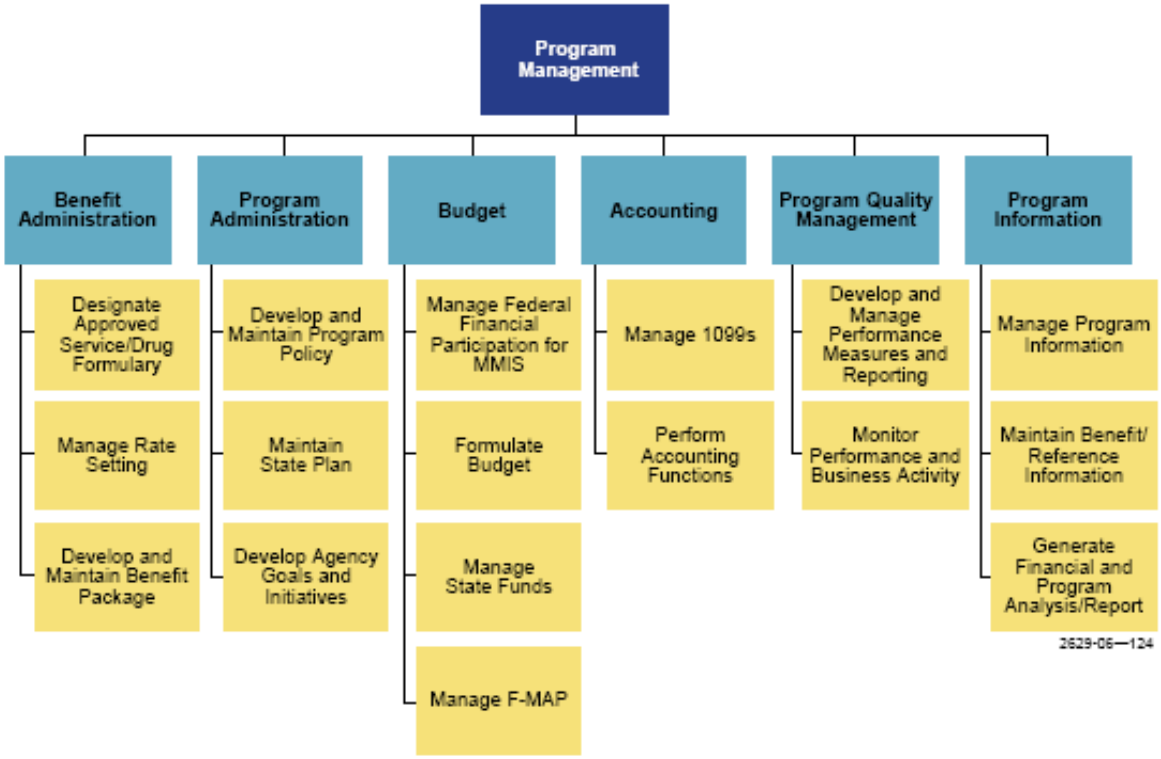
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
2. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
3. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process.

5.12.1 MITA to RI Medicaid Business Process Mapping

This RI Medicaid business area contains business processes from the MITA Program Management business area, which is shown below.

Figure 27: MITA Program Management



The RI Medicaid program performs all of the defined business processes:

- Designate Approved Service Drug Formulary
- Develop Agency Goals and Initiatives
- Develop and Maintain Benefit Package
- Develop and Maintain Program Policy
- Develop and Manage Performance Measures/Reporting
- Formulate Budget
- Generate Financial and Program Analysis Report
- Maintain Benefits-Reference Information

- Maintain State Plan
- Manage 1099s
- Manage FFP for MMIS
- Manage F-MAP
- Manage Program Information
- Manage Rate Setting
- Manage Rate Setting
- Manage State Funds
- Perform Accounting Functions

Table 15: RI Medicaid Program Management Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Manage F-MAP	Manage F-MAP	DHS, Budget and Accounting
2	Maintain Benefits-Reference Information	Maintain Benefits-Reference Information	DHS
3	Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report	DHS, Child and Family Services
4	Manage 1099s	Manage 1099s	Department of Administration, Office of Accounts and Control
5	Develop and Maintain Program Policy	Develop and Maintain Program Policy	DHS Medicaid Director
6	Manage State Funds	Manage State Funds	DHS, Budget and Accounting
7	Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures/Reporting	DHS, Child and Family Services
8	Manage RI Medicaid Program Information	Manage Program Information	DHS
9	Maintain State Plan	Maintain State Plan	DHS Medicaid Director

#	RI Medicaid Business Process	MITA Business Process	Owner
10	Perform Accounting Functions	Perform Accounting Functions	CFO, EOHHS
11	Designate Approved Drug Formulary	Designate Approved Service Drug Formulary	DHS Pharmacy Chief
12	Designate Approved Medicaid Service	Designate Approved Service Drug Formulary	DHS
13	Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	DHS
14	Manage Managed Care Rate Setting	Manage Rate Setting	DHS, Child and Family Services
15	Manage Standard RI Medicaid Rate Setting	Manage Rate Setting	DHS, Rate Setting Unit
16	Formulate Budget	Formulate Budget	DHS Medicaid Director
17	Develop Agency Goals and Initiatives	Develop Agency Goals and Initiatives	DHS Medicaid Director
18	Manage FFP for MMIS	Manage FFP for MMIS	DHS, Budget and Accounting

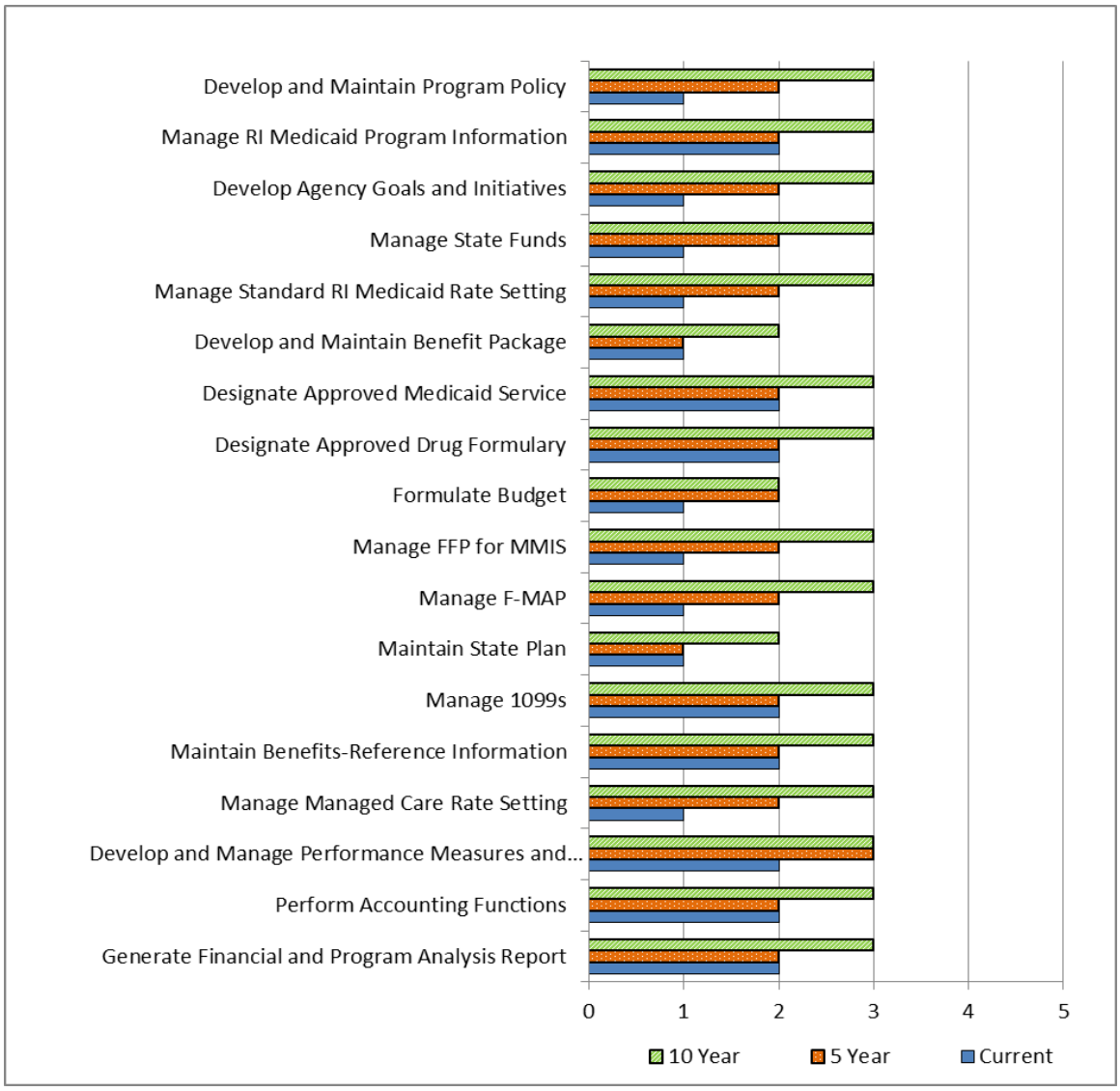
5.12.2 Program Management Business Process Maturity

Current View – The Program Management business processes for RI Medicaid are currently split between level 1 and level 2 business capabilities. Due to highly manual processing, non-standardization, and lack of integrated data, the majority of these processes currently rate at the lowest level of capability. While much of the processes remain manual, access to data is becoming easier with the implementation of the data warehouse.

5 Year View – Accuracy and consistency of data will support a level 2 within 5 years for most Program Management business processes. Many business processes within policy and planning area will see an increase in standardization and the use of tools to gather, record, communicate, and distribute information to the Medicaid Enterprise.

10 Year View – Use of data sharing standards and almost complete elimination of non-electronic data exchanges will support a level 3 capability for this business area within 10 years. Interagency collaboration, use of data sharing standards, and regional electronic information exchange will improve timeliness of communication and reporting. Standardized queries and automated alerts will help distribute updates to data sharing partners.

Figure 28: Program Management Business Capability Levels – 10 Year, 5 Year, & Current



5.12.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- The 2010 RI State Medicaid HIT Plan supports statewide efforts to develop Health Information Technology (HIT) solutions and promote Health Information Exchange (HIE). HIT/HIE will facilitate access to health information.[57]
- Ensuring a sustainable and cost-effective program is among the main goals of the States' Global Waiver Demonstration. This includes maximizing available service options.[58]
- Improving health outcomes through more organized care is a goal of the Global Waiver Demonstration. Aspects of this goal include enhanced access to preventive care and improved management of patients with complex medical conditions. This business process is instrumental to the planning efforts associated with these aspects.[59]
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[60]
- A goal of the Global Waiver is to encourage and reward health outcomes. Enhancements to managed care plan performance monitoring may create

[57] Executive Office of Health and Human Services/Department of Human Services, Rhode Island State Medicaid HIT Plan, August 6, 2010 Preliminary Draft
[58] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[59] ibid
[60] ibid

mechanisms that support the Department's goal of rewarding improved plan performance.[61]

- The Medicaid Director's vision of moving towards more managed care. Medicaid will play less of a role of an insurer and more of a purchaser.
- Enhancements to managed care plan monitoring and reimbursement methods will increase program accountability, which is a goal of the Global Waiver. These changes are expected to improve relationships with current and prospective plan partners, which may support managed care plan market access and competition for the benefit of the Medicaid program and its managed care enrollees.[62]
- As part of the Affordable Care Act, a new Medicaid Eligibility category will be mandatory. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents) with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment. Federal funds to implement the new Medicaid eligibility category could be leveraged for other member management improvements.[63]

Facilitators and Barriers

- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and

[61] ibid
[62] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[63] U.S Congress, Patient Protection and Affordable Care Act (H.R. 3590), Sec. 1331(e)(1)(B)

timeliness that are expected to improve the effectiveness of the claims-related components of this system and are critical to the efficient operation of this business process.

- Standardized tracking of prospective policy changes is not currently a priority for the department.
- Under the Global Waiver, the goal to redesign IT systems to take advantage of new technologies that improve program finance and integrity and adoption of best practices.[64]
- Under the Global Waiver, the goal to stimulate innovation transparency goal to disclose information about reimbursement rates and payments on a regular basis.[65]
- Privacy and security regulations may impede data sharing. Such rules do not appear to be keeping up with technology capabilities and business needs related to this business process.
- The method by which the FA receives encounter data is currently non-standard. There is data accuracy, integrity and timeliness issues with the current encounter data that impede the ability for the Department to utilize the encounter data for program management activities.
- A variety of incentives exist for health plans to submit timely and accurate encounter data. An encounter data component in the health plan capitation calculation provides health plans with an incentive to submit accurate, timely, and a consistent volume of data. HEDIS also provides incentive for health plans to process quality encounter data, including HEDIS awards. The 'default algorithm' is also another means of incentivizing health plans.

[64] Gary Alexander/Elena Niclella, The Global Waiver – Modernizing the Rhode Island Medicaid Program, Slide 5
[65] ibid

- Replacement of the State's Eligibility system, InRhodes. Scope of project to be determined as either an entire replacement for all RI social services or just a new Medical Assistance system specifically for Medicaid. Implementation of a new, state-of-the-art eligibility system will greatly facilitate increased capability within all member management functions.
- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.[66]

[66] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

5.13 Provider Management

The Provider Management business area as defined in the MITA 2.0 Framework is a collection of business processes that focus on:

- Enrolling/Disenrolling Providers;
- Recruiting potential providers;
- Supporting the varied needs of the provider population;
- Maintaining information on the provider; and
- Communicating with the provider community.

The goal of this business area is to maintain a robust provider network that meets the needs of both beneficiaries and provider communities and RI Medicaid to monitor and reward provider performance and improve health care outcomes.

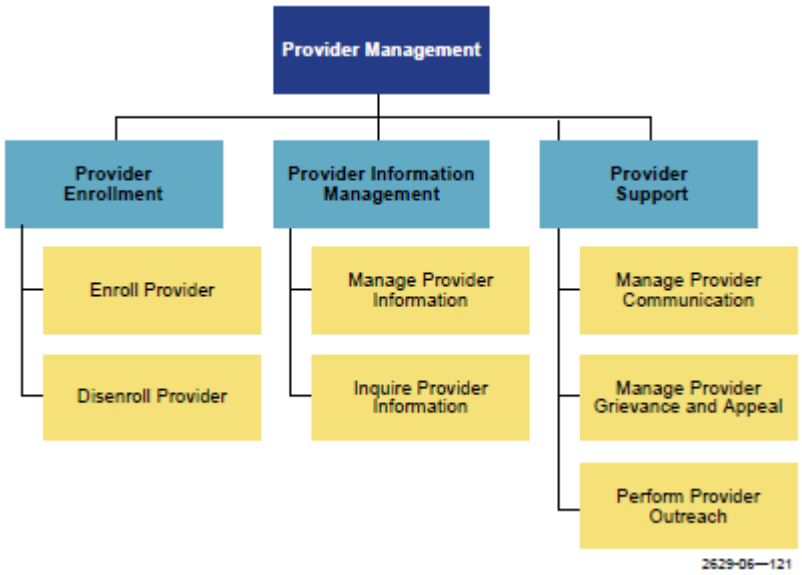
The rest of this section is organized into the following components:

1. **Mapping MITA to RI Medicaid** – where MITA framework processes are mapped to RI Medicaid business processes
4. **Business Process Maturity** – where current, 5 year future, and 10 year future business capabilities are assessed and forecasted
5. **Specific Planning Influences, Barriers & Facilitators** – where current or future initiatives will facilitate the maturity of the business process; or lack of any initiatives hinder the maturity of the business process

5.13.1 MITA to RI Medicaid Business Process Mapping

The RI Medicaid business area contains the MITA defined business processes from the Provider Management business area, which are shown below.

Figure 29: MITA Provider Management



There are seven (7) specific Provider Management business processes and the RI Medicaid program performs six of these processes:

- Enroll Provider
- Disenroll Provider
- Manage Provider Information
- Inquire Provider Information
- Manage Provider Communication
- Manage Provider Grievance and Appeal

Table 16: RI Medicaid Provider Management Mapping

#	RI Medicaid Business Process	MITA Business Process	Owner
1	Enroll RI Medicaid Provider	Enroll Provider	DHS
2	Disenroll RI Medicaid Provider	Disenroll Provider	DHS

#	RI Medicaid Business Process	MITA Business Process	Owner
3	Manage RI Medicaid Provider Information	Manage Provider Information	DHS
4	Inquire RI Medicaid Provider Information	Inquire Provider Information	DHS
5	Manage RI Medicaid Provider Communication	Manage Provider Communication	DHS
6	Manage RI Medicaid Provider Grievance and Appeal	Manage Provider Grievance and Appeal	DHS

The RI Medicaid Program does not currently perform the following business process:

- Perform Provider Outreach – included in the RI Medicaid process for Manage Provider Communication

5.13.2 Provider Management Business Process Maturity

Current View - Most business processes for Provider Management currently rate at a Level 1 business capability. Due to variations in types of enrollment, different processing methods (paper vs. electronic), different supporting technology, non-standardization, and lack of integration, the majority of these processes currently rate at the lowest level of overall capability.

5 Year View - Over the next 5 years business processes in support of Provider Management will become timelier and increasingly standardized, with some automation of business rules. Communication can be immediate using automated responses to providers. These improvements will assist in moving Provider Management business processes to a Level 2 capability.

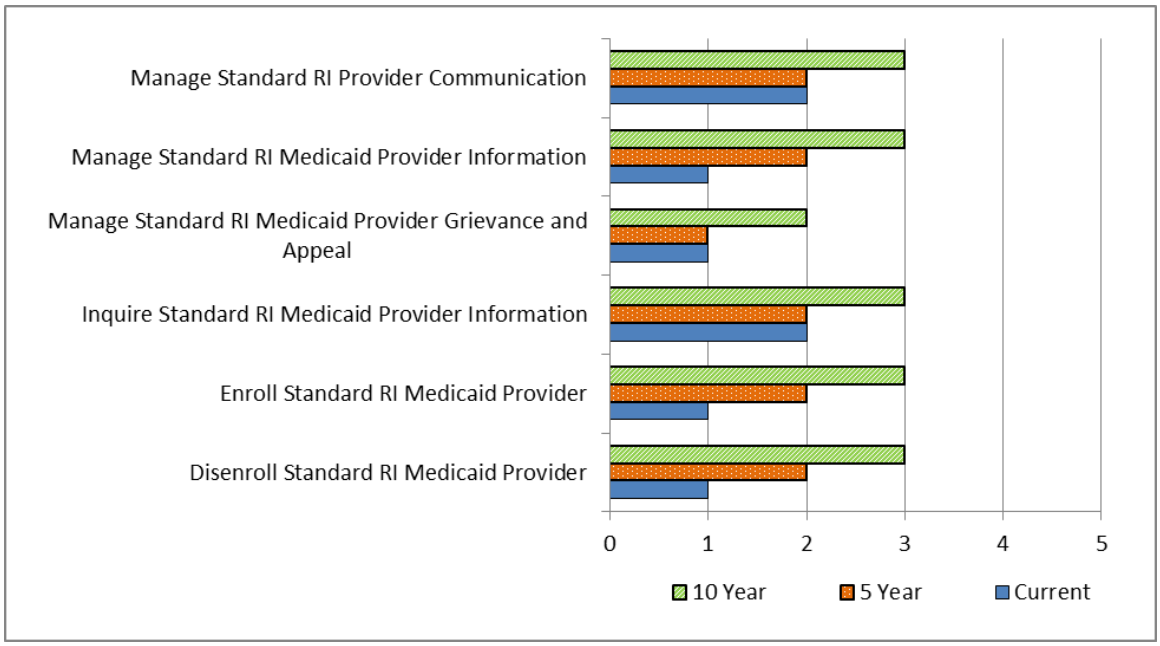
10 Year View - Over the next 10 years there will be significant changes to Provider Management that will allow all business processes to reach at least a Level 3. Changes will include nearly complete standardization of data and data exchanges, flexibility of business rules across programs, a shared Provider Registry for all RI

Medicaid providers, and integration of data across different Agencies that support the RI Medicaid program.

RI Medicaid may leverage some of the existing processes and supporting technology that rate at a higher level (i.e., with an increasing use of clinical data), such as Manage Provider Communication and Perform Provider Outreach.

The following chart illustrates each of the Provider Management business processes and their current, 5 and 10 year capabilities.

Figure 30: Provider Management Business Capability Levels – 10 Year, 5 Year, & Current



5.13.3 Strategic Planning Influences, Barriers & Facilitators

Strategic Planning Influences

- Ensuring that RI Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice is among the main goals of the States' Global Waiver Demonstration. This

business process contributes to the program's ability to make the right services available to individuals at the right time and in the right setting.[67]

- Improving health outcomes through more organized care is another goal of the Global Waiver Demonstration. An aspect of this may include increased enrollment in home and -based Services. This will require improved coordination with care managers (e.g., community-based or from within the RI Medicaid program), which may result in further enhancements to the care planning process.[68]
- A goal of the Global Waiver is to encourage and reward health outcomes. An aspect of this goal is expected to include increased enrollment in RIte Share/RIte Care Plans where beneficiaries would be linked to a medical "home" (e.g., PCP).[69]

Facilitators and Barriers

- The new provider enrollment process will utilize an online RI Provider Enrollment Portal application. The Provider Portal will streamline enrollment data collection and agreements through electronic submission, including the submission of an electronic signature and attestation.
- Enhancement of the existing MMIS is anticipated within the next 5 years. The enhanced system will provide increased flexibility; consistency and timeliness that are expected to improve the effectiveness of the authorization-related components of this system and are critical to the efficient operation of this business process.
- The healthcare reform plans for Rhode Island under discussion may result in increased enrollment in the RI Medicaid program, which could

[67] Executive Office Health and Human Services, Designated Medicaid Information July 1, 2009 – December 31, 2009, p. 2
[68] ibid
[69] ibid

necessitate additional provider enrollment to address access to care for recipients.

- A theme understood by EOHHS is the need for improved case management, including data integration. Enhancing the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated case management system will facilitate the Department's ability to among other things, ensure RI Medicaid beneficiaries are receiving the right service at the right time and in the correct setting.[70]

[70] Executive Office of Health and Human Services, EOHHS Strategic Technology Plan FY2011-FY2013, p. 7

6.0 GAP ANALYSIS

This section identifies gaps between the current business process capabilities performed within the RI Medicaid program and the future targeted capabilities for each. The level of information contained within the matrix is intended to be used by executive level staff as a quick reference for tracking where the RI Medicaid program currently rates in maturity and how current and/or planned projects and initiatives will or will not facilitate growth in maturity levels within the program.

Each MITA Business Area is shown with RI specific business processes identified. The Current "As-Is" rating represents the maturity of the business process in its current state. The 5 Year and 10 Year "To-Be" ratings represent the target goals in maturity for the Medicaid program. The value of "N/A" is used when the specific business process does not exist either in the current or future state. There are several business processes that currently do not have a formal process and are indicated as "N/A". There are also several business processes that currently exist for specific eligibility categories that will be rolled up into one standard process within 5 or 10 years. These business processes will have "N/A" for their 5 and/or 10 Year "To-Be" ratings.

The Deficiency column identifies the characteristics of the business processes that inhibit higher maturity ratings. These deficiencies will need to be addressed in the DHS Action Plan to reach the 5 and 10 year goals.

The Transition Plan identifies initiatives and planned projects that facilitate the maturity progression over the next 10 years and creates the "Roadmap" to MITA maturity. It also identifies when maturity goals are not supported by any planned projects and action is required by the DHS to ensure target capabilities are addressed appropriately.

Details that support the Current View (As-Is) findings can be found in Appendix A. Details that support the 5 and 10 year (To-Be) visions for the program are included in Appendix B.

6.1 Gap Analysis Matrix

MITA Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"	Deficiency	Transition Plan
Business Relationship Management	Establish RI Medicaid Business Relationship	1	1	2	• Program areas contact Budgets & Accounting via phone and email to facilitate the process for execution of an Interagency Agreement (IA). • Standards do not exist for initiating formal business relationships (e.g., establishing MOUs or ISAs) • Communication with business partners is not automated • Responses to questions are handled via phone or email • Program areas implement their own communication standards and practices independently	While ongoing initiatives within EOHHS and DHS, such as the Global Waiver will help introduce automation to improve timeliness and accuracy; **there are no concentrated efforts to mature the business process capabilities under Business Relationship Management.** In order to mature these business processes beyond a capability level of 1 within 10 years, DHS will need to focus efforts on things like increasing exchange of standardized agreements via email or using electronic document communication standards, automation of a centralized tracking of the business relationship; full interfacing between EOHHS programs.
Business Relationship Management	Manage RI Medicaid Business Relationship Communications	N/A	1	2		
Business Relationship Management	Terminate RI Medicaid Business Relationship	N/A	1	2		
Business Relationship Management	Manage RI Medicaid Business Relationship	1	1	2		
Care Management	Manage Immunization Registry	N/A	2	3	• Process requires manual chart review • All communication with providers, beneficiaries, and case managers is performed manually via phone, fax, and letters • Data are keyed manually into CDM, CSM and OMAR • Case Management systems do not exchange data with each other • CSM does communicate directly with InRhodes for eligibility purposes • There are no formal data exchanges supporting this process • There are a few guidelines governing the workflow • Outcomes and decisions may take several months	Enhancements to the current RI-MMIS will facilitate achievement of levels 2 and 3 business process capabilities within 10 years. Specifically, the requirement for implementation of a universal care management system. EOHHS understands the need for improved case management, including data integration. Enhancement the Community Supports Management (CSM) application or implementation of a new, agency-wide integrated care management system will facilitate the Department's ability to achieve a business capability level 3 within 10 years. Additionally, the recently published proposed rule (CMS-2296-P) makes it easier for states to provide home and community based services in the Medicaid program, similar to RI's Global Waiver. National initiatives like this will aid RI Medicaid in achieving the 5-10 year goals.
Care Management	Manage Case	1	2	3		
Care Management	Manage RI Medicaid Population Health	1	2	3		
Contractor Management	Inquire Contractor Information	1	1	3	• Many steps performed are manual • Applications are submitted on paper • Requires a large number of staff	The new online RI Provider Enrollment Portal application will help facilitate the 5 year maturity goals for many of the contractor management business processes related to communication,
Contractor Management	Perform Potential Contractor Outreach	1	2	3		
Contractor Management	Manage Administrative/Health Services Contract	1	2	2		

MITA Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"	Deficiency	Transition Plan
Contractor Management	Award Administrative/Health Services Contract	1	2	2	• Application format is relatively standardized • Each type of contract may be handled differently • Expiration of contracts does not trigger an automatic message to initiate procurement process	outreach and management of information. While ongoing initiatives within EOHHS and DHS, such as the Global Waiver will help introduce automation to improve timeliness and accuracy; **there are no concentrated efforts to mature the business process capabilities under Contractor Management.** In order to mature these business processes beyond a capability levels of 1 and 2 within 10 years, DHS will need to focus efforts on things like increasing exchange of standardized agreements via email or using electronic document communication standards, automation of a centralized tracking of the contractors; full interfacing between EOHHS programs.
Contractor Management	Manage Contractor Communication	N/A	2	3		
Contractor Management	Close out Administrative/Health Services Contract	1	2	2		
Contractor Management	Manage Contractor Information	1	1	3		
Contractor Management	Support Contractor Grievance and Appeal	1	2	3		
Member Management	Inquire RI Medicaid Member Eligibility	2	3	4	• Applications are paper-based and may be different depending upon eligibility category applying for (i.e. Katie Beckett and Adult Disabled utilize the DHS 1 and 2 forms) • Waiver programs introduce flexibility and access to care • Some information continues to be manually verified • BCCTP determination is done manually, outside of InRhodes • Supporting documentation continues to be manually verified • Process may take several days • Communication to members within BCCTP is done by hand written letters • Grievance and Appeal process is automatically included in member communication materials • Online access to file grievance or appeal is not available	DHS has both state and national initiatives that will facilitate significant maturity in this business area. Examples include: HIX, HIT, Health Care Reform and the Global Waiver. The DHS is currently working on requirements for the Eligibility HIX project which will include a new Medical Assistance determination system targeted for implementation in January 2016. A complete replacement of the state's eligibility system, InRhodes is targeted for 2018. Under a new CMS rule, supported by the Affordable Care Act, states may receive a 90 percent federal matching rate to assist states in the design, development, installation or enhancement of eligibility determination systems through December 31, 2015. RI intends to take advantage of this federal participation to support their HIX project. To reach the 5 -10 year goals of levels 3 and 4 capability, DHS must continue increasing the level of automation and standardization when conducting the business processes within this business area. Automated rules and enrollment coordination will allow beneficiaries to immediately enroll into programs in which they are eligible and most appropriate based on clinical need.
Member Management	Manage RI Medicaid Applicant and Member Communication	1	3	3		
Member Management	Determine BCCTP Eligibility	1	N/A	N/A		
Member Management	Disenroll RI Medicaid Member	1	3	4		
Member Management	Determine Standard RI Medicaid Eligibility	1	3	4		
Member Management	Determine Respite Care for Children Eligibility	1	N/A	N/A		
Member Management	Perform RI Medicaid Population and Member Outreach	1	3	4		
Member Management	Manage RI Medicaid Member Information	1	3	4		
Member Management	Manage RI Medicaid Member Grievance and Appeal	1	2	3		
Member Management	Manage BCCTP Member Information	1	N/A	N/A		
Member Management	Enroll Managed Care Member	1	3	4		
Operations Management	Authorize RI Medicaid Service	1	2	3	• Authorization processes are highly manual	Enhancements to the current RI-MMIS will facilitate

MITA Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"	Deficiency	Transition Plan
Operations Management	Inquire RI Medicaid Payment Status	2	3	4	and paper based • Clinical data is not exchange efficiently within the program • Lack of a care/case management system to support authorization business processes • TPL processes are largely nonstandard and lack integration.	achievement of levels 3 and 4 business process capabilities within 10 years. Specifically, focus on improved encounter data and reporting and introduction of automation and standardization within the authorization business processes. Complying with national initiatives, such as HIPAA, will facilitate continued maturity within the Operations Management business area. Additionally, the recently published proposed rule (CMS-2296-P) makes it easier for states to provide home and community based services in the Medicaid program, similar to RI's Global Waiver. National initiatives like this will facilitate need to increase automation and standardization in the prior authorization/care plan business processes. The planned MMIS replacement project targeted for completion in 2020 will support the 10 Year "To-Be" target maturity goals for the Operations Management business processes.
Operations Management	Prepare RI Medicaid Remittance Advice	3	3	4		
Operations Management	Prepare Medicare Premium Payment	1	N/A	N/A		
Operations Management	Prepare RIte Share Premium Payment	3	3	3		
Operations Management	Prepare Capitation Premium Payment	3	N/A	N/A		
Operations Management	Prepare RI Medicaid Provider and Premium EFT	2	3	4		
Operations Management	Price RI Medicaid Claim	2	2	3		
Operations Management	Edit and Audit RI Medicaid Encounter	1	2	3		
Operations Management	Edit and Audit RI Medicaid Claim	2	2	3		
Operations Management	Apply Void and Replace	2	2	3		
Operations Management	Authorize Personal Choice Waiver Service	1	N/A	N/A		
Operations Management	Calculate Medically Needy Spend-Down Amount	1	1	2		
Operations Management	Manage Hospital Cost Settlement	1	2	3		
Operations Management	Establish Care Plan	1	2	3		
Operations Management	Manage RI Medicaid Drug Rebate	2	2	3		
Operations Management	Manage RI Medicaid Recoupment	2	3	4		
Operations Management	Manage RI Medicaid TPL Recovery	1	2	3		
Operations Management	Apply RI Medicaid Claim Attachment	1	2	3		
Operations Management	Prepare REOMB	1	3	4		
Operations Management	Manage RI Medicaid Estate Recovery	1	2	3		
Operations Management	Prepare RIte Care Member Premium Invoice	3	3	3		
Program Integrity Management	Identify RI Medicaid Candidate Case	2	3	4	• An Excel file is used for case tracking and managing information related to provider and beneficiary investigations • Although basic case data are collected and reported in a standardized manner, investigative methods and standards may vary by case type and eligibility category • Outcomes may take several months • Cases are identified through a variety of	Enhancements to the current RI-MMIS will facilitate achievement of levels 3 and 4 business process capabilities within 10 years. Specifically, the requirement for implementation of a universal case management system. The planned MMIS replacement project targeted for completion in 2020 will support the 10 Year "To-Be" target maturity goals for the Operations Management business processes.
Program Integrity Management	Manage RI Medicaid Case	1	3	4		

MITA Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"	Deficiency	Transition Plan
					methods, including a variety of rich data sets • General access to State website for reporting potential fraud and abuse • Data collected is manually from various sources	
Program Management	Generate Financial and Program Analysis Report	2	2	3	• Process is "data driven" • DHS has to notify HP by the FACN process to update benefit package information • Cost reports are submitted on paper • Cost reports are not standardized • Updates to Agency Goals and Objectives are done manually • A formal process is not defined or documented • Updates to the State Plan are done manually • Process is not on a scheduled basis, only as-needed	Enhancements to the current RI-MMIS will facilitate achievement of levels 2 and 3 capabilities within 10 years for the rate setting and federal reporting functions within Program Management. Specifically, the requirements for the standardization and automation of cost reports used for rate setting as well as the automation of federal reports such as the CMS 64. While ongoing initiatives within EOHHS and DHS, such as the Global Waiver will help introduce automation to improve timeliness and accuracy in the remaining business processes; **there are no concentrated efforts to mature the business process capabilities under Program Management outside of those targeted for the MMIS enhancements.** In order to mature these business processes beyond a capability level of 2 within 10 years, DHS will need to focus efforts on accuracy and consistency in business processes. Introduce tools to gather, record, communicate and distribute information. Interagency collaboration, use of data sharing standards and information exchange will improve timeliness of communications and reporting
Program Management	Perform Accounting Functions	2	2	3		
Program Management	Develop and Manage Performance Measures and Reporting	2	3	3		
Program Management	Manage Managed Care Rate Setting	1	2	3		
Program Management	Maintain Benefits-Reference Information	2	2	3		
Program Management	Manage 1099s	2	2	3		
Program Management	Maintain State Plan	1	1	2		
Program Management	Manage F-MAP	1	2	3		
Program Management	Manage FFP for MMIS	1	2	3		
Program Management	Formulate Budget	1	2	2		
Program Management	Designate Approved Drug Formulary	2	2	3		
Program Management	Designate Approved Medicaid Service	2	2	3		
Program Management	Develop and Maintain Benefit Package	1	1	2		
Program Management	Manage Standard RI Medicaid Rate Setting	1	2	3		
Program Management	Manage State Funds	1	2	3		
Program Management	Develop Agency Goals and Initiatives	1	2	3		
Program Management	Manage RI Medicaid Program Information	2	2	3		
Program Management	Develop and Maintain Program Policy	1	2	3		
Provider Management	Disenroll Standard RI Medicaid Provider	1	2	3	• Applications are paper-based • Most activities are labor-intensive • Verification and validation of information is manual • Provider License Number is an identifier of record for paper submission of claims • Requests for disenrollment are not	The new provider enrollment process will utilize an online RI Providers Enrollment Portal application. Introduction of this automation streamlines enrollment data collection and agreements, which facilitates continued maturity in capability over the next 10 years. Enhancements to the current RI-MMIS will facilitate achievement of levels 2 and 3 business process capabilities within 10 years. Specifically, the
Provider Management	Enroll Standard RI Medicaid Provider	1	2	3		
Provider Management	Inquire Standard RI Medicaid Provider Information	2	2	3		
Provider Management	Manage Standard RI Medicaid Provider Grievance and Appeal	1	1	2		
Provider Management	Manage Standard RI Medicaid Provider Information	1	2	3		
Provider Management	Manage Standard RI Provider Communication	2	2	3		

MITA Business Area	RI Business Process	Current "As-Is"	5 Year "To-Be"	10 Year "To-Be"	Deficiency	Transition Plan
					automated • Local RI staff send paper disenrollment requests to DHS for processing • Responses are not immediate • Web-access to provider enrollment information is not available	requirements to automate the enrollment steps including an interface to DOH and enhance the current provider portal functions.
State Specific	Perform Provider Enrollment Certification	1	2	3	• Applications are paper-based • Most activities are labor-intensive • Verification and validation of information is manual • The NPI is not required for Certification	Refer to Provider Management above.

7.0 MITA ROADMAP

The RI MITA Roadmap is an implementation plan that charts the state's course for future transformation and improvement, also referred to as a Transformation Plan. The plan consists of planned projects and initiatives that collectively move the state from its current business capabilities to targeted future capabilities. This progression will occur in a series of manageable increments that meet the state's needs, priorities, and budget constraints and is consistent with the SS-A findings.

The figures that follow depict the current and planned projects and initiatives that support the 5 and 10 year maturity progression of the RI Medicaid program. Each project/initiative is referenced in the previous Gap Analyses section as a facilitator to close the deficiency that exists between the Current "As-Is" and Future "To-Be" views. Also shown is the maturity level progression over the next 10 years. The "As-Is", 5 Year "To-Be" and 10 Year "To-Be" levels are given for the overall business area. The Specific details on each business area's future target capabilities are contained in the Future View Section of this SS-A (Appendix B).

As visually displayed in the figures, there are two planned projects that will impact the maturity of the RI Medicaid business processes for the 10 year view; The MMIS Replacement and the Replacement of the State's Eligibility System. These projects are expected to be significant in scope and will dramatically advance the capabilities of the business processes impacted. These areas are:

- Member Management
- Care Management
- Operations Management
- Program Integrity Management
- Provider Management
- Program Management (limited impact)

Business areas not within the scope of the MMIS and Eligibility system replacement projects are still targeted for advancement in maturity capabilities. The results of the Future "To-Be" Views (Appendix B) show progression, although minimal, in all areas of the RI Medicaid program for the 10 year outlook. CMS "requires states to align to and advance increasingly in MITA maturity…" and "to complete and make measurable progress in implementing their MITA roadmaps."[71] To adhere to this requirement and to meet the target goals identified and documented in RI's Future View (Appendix B), the DHS must plan for additional work not currently planned for. The business areas with 10 year capability goals not addressed by planned projects are:

- Business Relationship Management
- Contractor Management
- Program Management (those business processes related to policy/planning, budgeting and the state plan)

The gap between a State's current capabilities and its targeted capabilities is the State's basis for establishing its transition and implementation plan. Failure to make progress on the MITA Transition Plan may result in RI's loss of previously approved 90/10 funding. The state needs to address the above mentioned business areas 10 year capability goals not supported by any future initiates and close the gap between the current view and the targeted capabilities outlined in Appendix B.

CMS requires a state's MITA Roadmap to address key activities and milestones covering a 5 year outlook to be updated annually. This SS-A included projects through the entire 10 year span of the targeted Future View capabilities (see Appendix B). All state targeted future capabilities for the 5 year outlook are covered by the projects and initiatives found in the figure below.

[71] CMS, Enhanced Funding Requirements: Seven Conditions and Standards, pg. 6

Figure 31 MITA Implementation Roadmap Timeline by Business Area

Business Relationship Management

1 — 1 — 2

As-Is — 5 Yr To-Be — 10 Yr To-Be

ID	Project Name	Start	Finish	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
				Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4
1	RI-FANS Electronic Bids	1/1/2011	1/1/2011										
2	TBD	1/1/2011	1/1/2011										

There are no planned projects to support the target capabilities for this business area's 10 year To-Be goals

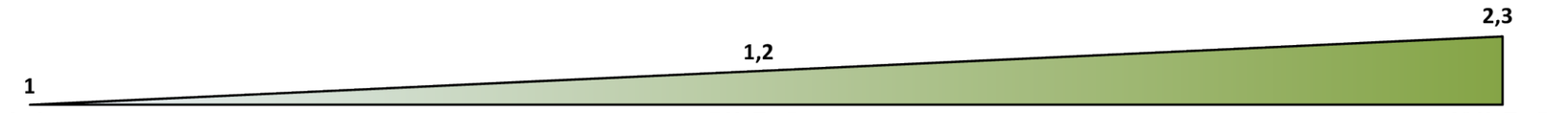
Care Management

1 — 2 — 3

As-Is — 5 Yr To-Be — 10 Yr To-Be

ID	Project Name	Start	Finish	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
				Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4
1	RIte Resources	4/1/2011	10/31/2011										
2	MMIS Reprocurement	1/4/2011	6/20/2012										
3	MMIS Takeover and Enhance	3/1/2012	2/28/2017										
4	MMIS Replacement	1/1/2016	12/31/2020										
5	Global Waiver Demonstration	1/1/2011	1/14/2014										
6	CurrentCare (HIE)	1/1/2011	4/7/2011										
7	Human Services Data Warehouse	1/1/2011	3/31/2011										
8	CSM Global Waiver Enhancements	1/1/2011	9/30/2011										
9	Patient Protection & Affordable Care	1/1/2011	12/31/2020										

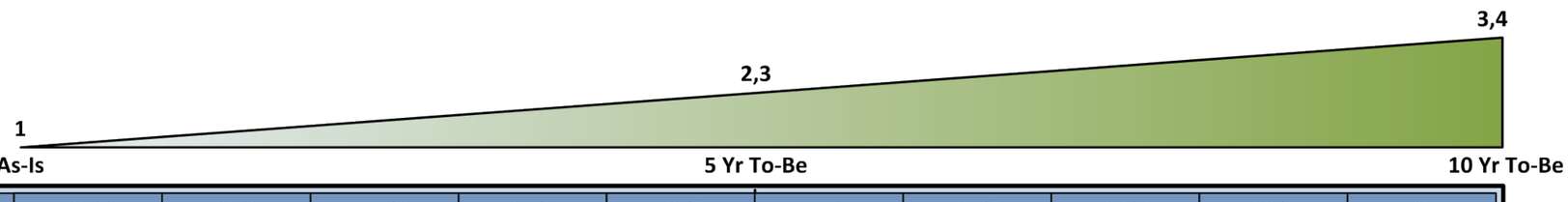
Contractor Management



ID	Project Name	Start	Finish	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
				Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4
1	RI-FANS Electronic Bids	1/1/2011	1/1/2011										
2	Provider Portal Phase 1	1/1/2011	7/3/2011										
3	TBD	1/1/2011	1/1/2011										

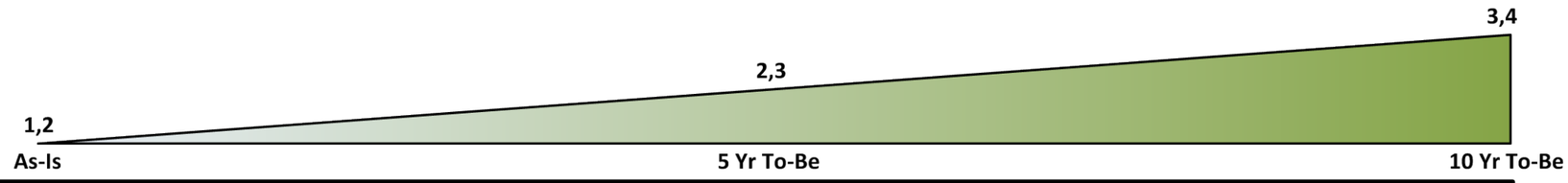
There are no planned projects to support the target capabilities for this business area's 10 year To-Be goals

Member Management



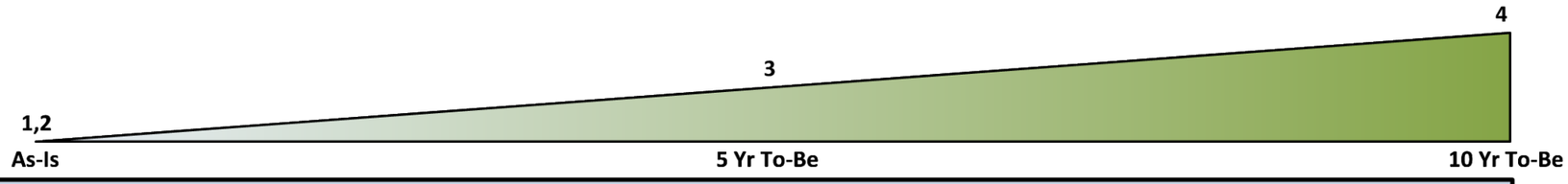
ID	Project Name	Start	Finish	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
				Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4
1	Enhancements to Benefits Screener	1/1/2011	6/30/2011										
2	MMIS Reprocurement	1/1/2011	6/17/2012										
3	MMIS Takeover and Enhance	3/1/2012	2/28/2017										
4	MMIS Replacement	1/1/2016	12/31/2020										
5	Human Services Data Warehouse	1/1/2011	3/31/2011										
6	CSM Global Waiver Enhancements	1/1/2011	9/30/2011										
7	HIX – Phase 1	4/1/2011	1/1/2014										
8	HIX – Phase 2 & 3	7/1/2013	1/1/2018										
9	Patient Protection & Affordable Care	1/1/2011	12/31/2020										

Operations Management



ID	Project Name	Start	Finish
1	RI EHR Initiative	1/1/2011	12/31/2020
2	National Correct Coding Initiative	1/1/2011	10/31/2011
3	MMIS Reprocurement	1/1/2011	6/17/2012
4	MMIS Takeover and Enhance	3/1/2012	2/28/2017
5	MMIS Replacement	1/1/2016	12/31/2020
6	Global Waiver Demonstration	1/1/2011	1/14/2014
7	CurrentCare (HIE)	1/1/2011	4/7/2011
8	Human Services Data Warehouse	1/1/2011	3/31/2011
9	CSM Global Waiver Enhancements	1/1/2011	9/30/2011
10	HIPAA 2 837	1/1/2011	4/1/2012
11	Transition to 5010	1/3/2011	1/1/2012
12	ICD-10 Implementation	1/3/2011	10/1/2013
13	Unique Health Plan ID (Tentative)	10/1/2012	10/1/2012
14	Claim Attachments (Tentative)	12/8/2015	12/8/2015
15	Patient Protection & Affordable Care	1/1/2011	12/31/2020

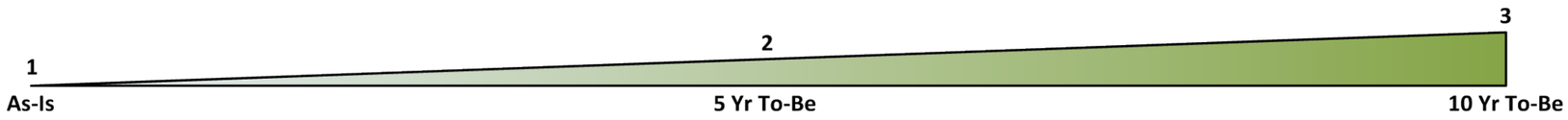
Program Integrity Management



ID	Project Name	Start	Finish
1	National Correct Coding Initiative	1/1/2011	10/31/2011
2	MMIS Reprocurement	1/1/2011	6/17/2012
3	MMIS Takeover and Enhance	2/9/2012	2/7/2017
4	MMIS Replacement	1/1/2016	12/31/2020
5	BHDDH Single Payment System	4/3/2011	4/3/2011
6	Patient Protection & Affordable Care	1/1/2011	12/31/2020

2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 (Q1 Q2 Q3 Q4 each)

Program Management



ID	Project Name	Start	Finish
1	MMIS Reprocurement	1/1/2011	6/17/2012
2	MMIS Takeover and Enhance	3/1/2012	2/28/2017
3	MMIS Replacement	1/1/2016	12/31/2020
4	TBD	1/1/2011	1/1/2011

2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 (Q1 Q2 Q3 Q4 each)

There are minimal planned projects to support the target capabilities for this business area's 10 year To-Be goals

Provider Management

ID	Project Name	Start	Finish
1	Provider Portal Phase One	1/3/2011	7/1/2011
2	MMIS Reprocurement	1/1/2011	6/17/2012
3	MMIS Takeover and Enhance	3/1/2012	2/28/2017
4	MMIS Replacement	1/1/2016	12/31/2020
5	Human Services Data Warehouse	1/1/2011	3/31/2011
6	Unique Health Plan ID (Tentative)	10/1/2012	10/1/2012
7	Patient Protection & Affordable Care	1/1/2011	12/31/2020